中国太平
CHINA TAIPING

中国太平保险(新加坡)有限公司
CHINA TAIPING INSURANCE (SINGAPORE) PTE. LTD.
3 Anson Road #16-00 Springleaf Tower Singapore 079909
Tel: 6389 6111 Fax: 6222 1033
Website: www.sg.cntaiping.com
Co. Reg. No. 200208384E

WORK INJURY COMPENSATION INSURANCE
NOTICE OF ACCIDENT

AGENCY ______________________ CLAIM NO. ______________

THE EMPLOYER

Name of Policyholder			
Business		Policy No	
Address			
		Tel No	

THE INJURED PERSON

Name of the injured person					
Nationality		Age		Sex	
NRIC / Work Permit No				Martial Status	
Local Address					
Domicile					

State occupation in which the injured person is employed	
On what work was the injured person engaged at the time of the accident ?	
Was the injured person actually working when the accident occurred ?	
Is the injured person in your direct employ ? If not, give name and address of Contractor.	
When did the injured person enter your service ?	
Name of hospital taken to	
In or Out-Patient	
State whether Still in hospital, or when discharged	
Is the injured person being medically attended ? If so, please state by whom	
Was the injured person free from Physical Infirmity at the time of the accident? If not, please give particulars.	
State whether returned to work, and if so, when ?	
Is the injured person able to do partial work ?	
What is the probable period of disablement ?	

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THE ACCIDENT

Please state, date & time of accident	
Place of accident	
Upon what date did you receive notice of the accident and from whom?	
On what date did the injured person actually cease work?	
How exactly did the accident occur?	
If the injury was caused by machinery or gearing (a) Whether it was fenced or guarded? (b) Was it being cleaned whilst in motion?	
What was the general nature of the contract or work going on?	
State regions, nature and extent of injury?	
Was the injured Person under the influence of drink or drugs at time of the accident?	
Was he guilty of any misconduct or disobedience to orders or rules? If so, please give full particulars.	
State through whose neglect the accident occurred, if any	
Please give name and address of any person who witnessed the accident	
On what date did you make a report of the accident to the Commissioner for Labour & enclose copy of Form A / I report	

On Policy Commencement (Applicable for Annual Policy Only)

No of Employees	Category / Description of Occupations	Actual Annual Wages, Salary & Other Monetary Earnings*	No of days worked per week

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The monthly wage of the injured person is calculated as follows:
(to enclose copies of the salary vouchers for past 12 months prior to the accident)

Month (or other period)	Cash Wages Paid	Bonuses, Value of Fee Quarters of other Allowances	Total
....	$	$	$ ....

Additional particulars for Fatal Cases only

(a) Please give full particulars of members of family of deceased. Kindly state:- Names, addresses, relationship, age and occupation.

(b) Please advise particulars of Death Inquiry re deceased. Kindly state date and place of hearing of Death Inquiry.

(c) Please forward Death Certificate and Post-mortem report.

DATA PRIVACY STATEMENT

In accordance with the **Personal Data Protection Act 2012**, I consent to the collection, use, disclosure of and/or process of my personal data (whether contained in the Claim Form or otherwise obtained) by China Taiping Insurance (Singapore) Pte Ltd, its affiliates and service providers (within or outside Singapore), for the purpose relating to the evaluation of the claim and to provide advice and information relating to the claim to me by Short Message Service (SMS), Multimedia Messaging Service (MMS) and fax messages (notwithstanding the registration of my telephone or mobile number in the Singapore's Do Not Call Registry)

Yes, I have read and agreed to the above Data Privacy Statement.

....
Signature of Claimant

Name:

NRIC/FIN/Passport No

I / We hereby declare that all the statements contained in this Form are true and correct to the best of my / our knowledge and I / We undertake to advise the Company promptly of all developments in connection with any claim.

Date :

....

Signature of Employer

Note

1. **The issue of this Form which is without prejudice to the terms of the Policy is not to be taken as an admission of liability by the Company.**
2. **Full particulars of the accident are to be furnished by the Employer.**
3. **If any details of information are not readily available, please forward this Form without delay, and advise the missing details as soon as possible to the Company.**
4. **All written communications received by the Employer concerning the accident should be forwarded at once to the Company.**
5. **On receipt of the particulars the Company may, if it so require, ask for a medical certificate to be supplied.**