Tokio Marine Insurance Singapore Ltd.

Company Reg. No. : 192300014M

20 McCallum Street
#09-01 Tokio Marine Centre
Singapore 069046
Tel : (65) 6221 6111 Fax : (65) 6225 9887
Email : tmis@tokiomarine.com.sg
Website : www.tokiomarine.com.sg

Work Injury Compensation Accident Report Form

(the company does not admit liability by the issuance of this form)
Particulars of every accident to be furnished and signed by the employer.

FGA Claims Fax No (65) 6225 9887

Employer Information

Policyholder: ______________________________

____

Policy No: ______________________________

Address: ______________________________

____

Tel No/email: ______________________________

____

Contact Person: ______________________________

Business: ______________________________

Total Number of employees: ______________

Are you GST Registered? ☐Yes ☐No

Agency/Broker: ______________________________

Do you have any other insurance that will cover this loss? ☐Yes ☐No If Yes, please provide details:

____

The injured person

Name:______________________________

NRIC/Passport/Work Permit No:______________

Nationality: ______________________________

Age: ____________ Sex: ☐Male ☐Female

Local Address: ______________________________

____

No of working days per week : ______________

Occupation of injured: ______________________

What was injured doing when accident happened:___

____

Is injured your employee? ☐Yes ☐No

If Yes, employment date/years of service: _________

If No, who is injured's employer & relationship with you

____

____

Has injured been medically examined: ☐Yes ☐No

If No, why? ______________________________

Name of hospital (or clinic) taken to: ______________

______________ ☐Inpatient ☐Outpatient

(Please fill in clinic's name if not hospitalized)

Admitted on: _________ Discharged On: _________

Has injured returned to work?

☐ Yes on ______________________________

☐ No, estimated period of disablement _________
Can injured do partial work? ☐Yes ☐No

Are you satisfied that injured met with a bona fide accident of employment? ☐Yes ☐No

Nature/Region of Injury: ______________________

____

______________ on the ☐ Left ☐ Right

For fatal accident:

1) State official cause of death : ______________

____

2) Will an enquiry be held?

☐Yes (please supply copy of enquiry notes)
☐No (please supply post mortem or medical certificate)

Additional Information

For fatal cases and cases where injured is unable to take care of his/her daily affairs, please provide a separate listing stating dependent's name, addresses, relationship, age, and occupation.

The Accident

Date: ____________________Time:____________

Place:______________________________

When were you notified of accident? ____________

Who notified you of accident? ______________
(If in writing, please attach to this form)

Date injured actually ceased work ______________

State the general nature of work going on when the accident happened? ______________________

Explain the accident in detail:

If machinery used, state what machinery

Was injured under the influence of drugs or alcohol at the time of accident? ☐Yes ☐No

Was injured guilty of any misconduct or disobedience to order or rules? ☐Yes ☐No
If Yes, give details

Whose neglect caused accident?

Any witnesses to the accident? ☐Yes ☐No

Witness Name/Employer/Tel:

Was accident reported to Ministry of Manpower, Commissioner for Labour? ☐Yes ☐No
If Yes, please attach a copy of ireport or Form A

If No, reasons:

General Documents Required:
a) Claim Form duly completed and signed
b) Accident Report Form A or ireport with MOM
c) Police Report (if applicable)
d) Original medcal certificate and medical bills
e) NRIC/Work Permit/Passport (Copy with photo shown)
f) All third party correspondences, unanswered
g) Relevant contracts to show relationship between insured and subcontractor
h) Salary Vouchers (12 months before date of accident)
Please submit above as applicable. We will write to you separately for further information as necessary.

Statement of Wages
Statement wages which have fallen due for payment to injured in the employ of insured for 12 months prior to the date of accident, or wages earned during such shorter period as injured may have been in insured's service, stating the date in which he was engaged.

Month/Year	Basic Wages	Overtime, Bonus, Value of free quarters, Other allowances
Total		
	Total including all allowance	

Important Notice: The insured person must, in the event of a claim, advise the company as to any other insurance that they may have covering the same risk.
Declaration: I/we hereby declare and warrant that all the answers given above to be true. I/we accept that insurers would be at liberty to deny liability in part or in full if the above written answers are false or inaccurate in any aspect.

Employer's Signature & Co Stamp :

Name :

Date :

Please return completed claim form to: Tokio Marine Insurance Singapore Ltd, 20 McCallum Street #09-01, Tokio Marine Centre, S'pore 069046. Fire & GA Claims Dept, Fax : 6225 9887

Please attach another piece of paper if place provided is insufficient.