Work Injury Compensation

CLAIM FORM

Policy Number

SECTION A: COMPANY DETAILS

Name of your Company

Address of your Company

Contact Number

Email Address

Company/Business GST Registration Number

SECTION B: INJURED WORKER DETAILS

Name(as per NRIC/FIN)

NRIC/FIN No.

Nationality

Date of Birth

Mobile No.

Occupation

Date of Employment

No. of working days per week

Please provide in detail the job scope of the worker under your employment.

Are you the immediate employer of the worker? ☐ Yes ☐ No

If No, please provide the company name and address of the direct employer.

SECTION C: ACCIDENT DETAILS (Complete this section if you have not lodged an iReport to the Ministry of Manpower)

Date and Time of Accident

Location of Accident

Please provide in detail an account of the accident.

Was there a witness to the accident? ☐ Yes ☐ No

If Yes, please provide the name(s) of the person(s).

Please provide details of the injury sustained (state injured body part and extent of the injury).

SECTION C: ACCIDENT DETAILS (Complete this section if you have not lodged an iReport to the Ministry of Manpower) *(continue)*

When was the first medical treatment sought after the accident? Please provide the name of the clinic/hospital.

If the worker was hospitalised, please provide the duration of the hospitalisation and if there was a follow-up treatment required?

SECTION D: ADDITIONAL INFORMATION BY POLICYHOLDER

Was the worker under the influence of alcohol or drugs at the time of accident? ☐ Yes ☐ No
If Yes, please provide details.

When did the worker return to work?

Did the accident take place at the project site? ☐ Yes ☐ No
If Yes, please provide the name of the main contractor, insurance company and policy number.

SECTION E: WORKER'S GROSS MONTHLY EARNINGS DURING THE 12 MONTHS PRECEDING THE DATE OF ACCIDENT

Month	Gross Monthly Earnings
Total	
Average	

SECTION F: PLEASE COMPLETE THIS SECTION IN ACCORDANCE TO THE MEDICAL BILL AND MEDICAL LEAVE DUE TO THE ACCIDENT

Medical bills incurred				Medical leave incurred		
Date	Clinic/Hospital	Invoice no.	Amount paid	From	To	Type of leave

SECTION G: DOCUMENTS REQUIRED TO SUPPORT YOUR CLAIM

1. A copy of the iReport (a report lodged with Ministry of Manpower).
2. The original medical bills.
3. The medical leave certificates.
4. A copy of the salary voucher of the worker 12 months before the date of the accident.
5. A copy of the work permit.
6. A copy of the inpatient discharge summary report if the worker was hospitalised or any diagnostic investigation report.
7. A copy of the contractual agreement and the insurance policy from your main contractor if the accident happened at project site.
8. A copy of the Police Report if any.
9. All other relevant documents to support the claim.

SECTION H: DECLARATION AND AUTHORISATION

☐ I/We declare that the information provided is, to the best of my knowledge, correct in every detail. I agree that if I/We have made any false or fraudulent statements or suppress, conceal or falsely state any material facts whatsoever, either now, or in the future, with regard to this claim, the Policy shall be void and all rights of recovery in respect of past or future claims, shall be forfeited.

☐ I/We consent to Singapore Life Ltd. ("Singlife") (and Singlife related group of companies) collecting, using and/or disclosing my/our personal data for the processing of the above transaction and such other purposes ancillary or related to the administering of the policy(ies), account(s) and/or managing my/our relationship with Singlife.

I/We also consent to Singlife (and Singlife related group of companies) disclosing and transferring my/our personal data to Singlife (and Singlife related group of companies) and their respective third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.

I/We have read and understood Singlife's Data Protection Notice which may be found at https://singlife.com/en/pdpa. Singlife's Data Protection Notice may be updated from time to time without notice. I/We am/are aware that I/we should visit your website regularly to ensure that I/we am/are well informed of the updates.

☐ I hereby authorise any hospital physician, other person, who has attended or examined me, to furnish Singapore Life Ltd., or its authorised representatives, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorisation shall be considered as effective and valid as the original.

Date

Signature of the Authorised Person of Insured & Company Stamp

Name of the Authorised Person of Insured

Please send completed and signed physical form with any receipts and documents to support your claim to:
General Insurance Claims
Singapore Life Ltd.
4 Shenton Way, #01-01, SGX Centre 2 Singapore 068807

Note: The acceptance of this form is NOT an admission of liability on the part of Singapore Life Ltd.
If there are no original receipts requirement, you can submit via email to gi_claims@singlife.com.