

### Personal Accident Claim Form

Policy Number		Policy Holder's Full Name	
---------------	--	---------------------------	--

**Important Notice**

1. The Policyholder and/or the claimant must truthfully declared the information and particulars to the best of your / their knowledge and belief.
2. The acceptance of this form is not in itself an admission of liability on the part of the Company.
3. If the claim is found to be fraudulent, or if any fraudulent means or devices are used to obtain any benefit under this policy, the policy will be rendered void.

This form is issued without admission of liability.

Claimant Details			
Claimant Full Name		Claimant NRIC / FIN No.	
Email		Mobile No.	

Accident & Injury Details			
If you are claiming more than one loss, please indicate the first date of loss.			
Date of Accident		Time of Accident	Location of Accident
Total Amount claimed			
Type of Accident	<input type="checkbox"/> Outpatient Medical Expenses / In-Hospital Medical Expenses / Accidental Dental Expenses <input type="checkbox"/> Ambulance Fee <input type="checkbox"/> Kidnap Benefit <input type="checkbox"/> Bereavement Grant (as a result of accident) <input type="checkbox"/> Child Education Grant	<input type="checkbox"/> Snatch Theft <input type="checkbox"/> Accidental Death <input type="checkbox"/> Total Permanent Disablement <input type="checkbox"/> Temporary Total Disablement <input type="checkbox"/> Temporary Partial Disablement	
Have you injured the same part before? (Yes / No)			
Is this your job related injury? (Yes / No)			
Description of Accident			
Description of Injury Sustained (e.g. body part injured, injury type)			
Have you made a claim against any other party in respect of this event? <span style="float: right;">If yes, please provide: (Yes / No)</span>			
Name of other party / Insurance company			
Policy number/ reference number of other party/ Insurance company			
Description of claim made against other party/insurance company			

**Documents Required for Claim Assessment**

- Medical Certificates
- Original Final Hospital Bills / Medical Bills / Dental Bills / Ambulance Bills
- Medical Reports / Inpatient Discharge Summary - if any
- Police Report (for kidnap cases, validation of kidnap by police is required) / Accident Report – for traffic accident claim, etc.
- Death Certificate
- Birth Certificate / NRIC - if claimant is other than insured
- Receipts of lost item

**Declaration**

- 1) [Declaration] I/We declare that the information given in this form is true and correct to the best of my knowledge and belief.
- 2) [Authorization] I/We hereby consent to and authorize the medical practitioner involved in the claimant's care to discuss and disclose treatment details and discharge arrangements with and to Etiqa Insurance Pte Ltd. I/We agree that a copy of this consent shall have the validity of the original.
- 3) [Customer's Data Privacy Consent] I/We further declared that the information written in this claim form or held by Etiqa Insurance Pte Ltd whether contained in my/our insurance application or otherwise obtained may be used and disclosed to your authorized staff, associated individuals and/or companies or any independent third parties (within or outside Singapore) who will provide claims administrative, advice and/or information or claims services in relation to my/our claim. I/We understand my/our data that may also be used for audit, business analysis and reinsurance purposes. My/Our signature below will signify this consent.

I/We agreed to abide the declaration and terms and conditions.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Insured  
Company's stamp (if applicable)