Etiqa Insurance Pte. Ltd. (Company Reg. No. 201331905K)
One Raffles Quay #22-01 North Tower Singapore 048583 |T +65 6336 0477 | F +65 6339 2109 | www.etiqa.com.sg

Work Injury Compensation Claim Form

Policy Number		Intermediary	

Important Notice
1. Please complete this form fully and return to Etiqa.
2. By answering these questions, it does not imply that the injured person is making, or will make a claim.
3. This form is sent without prejudice to the terms and conditions of the Policy.
4. All questions must be answered.

This form is issued without admission of liability.

The Employer			
Name of Insured		Nature of Business	
Address			
Email		Business Tel Number	
Total Number of Employees			
GST Registration (Yes / No)		If yes, Please provide GST Number	

The Injured Person							
Name							
Gender		Age		Nationality		NRIC / PP No	
Address							
Mobile Number		Business Tel Number					
Occupation							
Was the injured person engaged in this occupation when the accident occurred? (Yes / No)							
When did the injured person join the company?							
Is the injured person under your direct employment? If not, give name and address of employer.							

The Accident					
Name		Time		Place	
When did you receive notice of the accident?					
Who send the notice of the accident to you?					
Please explain in detail, how the accident happened?					
Was the accident caused by an equipment / machinery? (Yes / No)					
If yes, Type of equipment / machinery.					
Does the equipment / machinery has safety features, ie barrier / frame / guard? (Yes / No)					
Was the equipment / machinery in motion at the time of accident? (Yes / No)					
Was injured under the influence of intoxicating liquor / drugs? If yes, please provide full details.					

Was the injured person of any misconduct or disobedience to orders or rules? (Yes / No)	
State the names of any person who witnessed the accident details	
Was anyone supervising the injured at the time of the accident? (Yes / No)	
In your opinion, was the injured responsible for the accident? (Yes / No)	
Has the accident been reported to the MOM office and Police? (Yes / No)	

The Injury			
Nature and region of injury			
On what date did the injured person cease work?			
Name of the hospital that the injured person is taken to			
In or out-patient?			
State whether still in hospital, or date of discharge?		Date of Discharge?	
Has the injured person been medically examined? (Yes / No)		If no, free medical examination offered? (Yes / No)	
Date of Return to Work		If he hasn't return to work yet, when is he likely to be able to return to work?	
What is the probable period of incapacity?			
Is this a death claim? (Yes / No)			
If yes, add dependant lists. If below fields are not enough, please enclose in another paper.			

Dependant Lists

Name	Address	Age	Relationship	Occupation
Date of coroner's inquest, if any.				

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The Earnings

(Please complete the following for the 12 months prior to the accident)
"EARNINGS" means – All payments in cash, for wages or salary, overtime, bonus and all other remuneration for work done (except travelling allowance or expenses, EPF or CPF contributions and special expenses incurred by reason only of the nature of employment) plus the value of all privileges or benefits in kind, for food, fuel, quarters and any other which capable of being estimated in money (except any travelling concession).

Month	Total Earnings			
	Wages		Bonus, Overtime, value of free quarters and any other allowance etc.	
	$	cts.	$	cts.
Total				
No. of days worked per week by injured employee				

Documents Required for Claim Assessment

- ☐ I-report lodged with the Ministry of Manpower
- ☐ Police report (if any)
- ☐ Post mortem report (for death claim)
- ☐ Death certificate (for death claim)

Declaration

1) [Declaration] We certify that the foregoing is true and correct to the best of our belief.

2) [Customer's Data Privacy Consent] We further declared that the information written in this claim form or held by Etiqa Insurance Pte Ltd whether contained in our insurance application or otherwise obtained may be used and disclosed to your authorised 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 our claim. We understand our data that may also be used for audit, business analysis and reinsurance purposes. Our signature below will signify this consent.

_____
Date

_____
Signature of Insured
Company's stamp (if applicable)