HL Assurance

Work Injury Compensation Claim Form

The acceptance of this Form is NOT an admission of liability on the part of HL Assurance Pte. Ltd.. Any documentary proof or report required by HL Assurance Pte. Ltd. shall be furnished at the expense of the Policyholder or Claimant.

PARTICULARS OF INSURED

Name of Company Nature of Business Address of Company Total No. of Employees		Policy No. Period of Insurance Is your Company GST registered? Name of Intermediary (if any)
Tel. No.	Fax No.	E-mail

PARTICULARS OF INJURED WORKER

Name (as in NRIC/Passport/Work Permit) NRIC/Passport/Work Permit No. Gender ☐ Male ☐ Female Date of Birth Address	Nationality Marital Status Occupation No. of working days per week Date of Employment	Is the injured in your direct employment? ☐ Yes ☐ No If not, please give the name and address of his direct employer. Was the injured free from any physical defect or infirmity at the time of accident? ☐ Yes ☐ No If no, please provide details. Would such physical defect or infirmity have contributed towards this accident? ☐ Yes ☐ No If yes, please provide details.

DETAILS OF ACCIDENT (PLEASE COMPLETE ALL QUESTIONS)

Date of accident	Time of accident	Location of accident (please specify the country if it is outside Singapore)

When did you receive notice of accident and from whom?

When did the injured actually cease work?

Explain fully how did the accident occur (if machinery is involved, state the type of machinery).

What was the general nature of the work or contract going on when the accident occurred?

State the names and contact numbers of any witnesses to the accident.

Was the injured under the influence of alcohol or drugs at the time of accident? ☐ Yes ☐ No If yes, please provide details.	
Was the injured guilty of any misconduct or disobedience to orders or rules? ☐ Yes ☐ No If yes, please provide details.	
Did this accident occur as a result of another person's negligence? ☐ Yes ☐ No If yes, please provide details.	
Are you satisfied that the injured has met with a bonafide accident of employment? ☐ Yes ☐ No	
Was this accident reported to Ministry of Manpower? ☐ Yes ☐ No If yes, please attach a copy of i-report. If no, please provide reason of non-reporting.	
Did the injured met with any previous injury under your employment? ☐ Yes ☐ No If yes, please provide details.	

DETAILS OF INJURY

State the name of hospital/clinic where the injured received treatment.	
Please provide details of injuries sustained, indicating the injured body part and nature of injury.	
Was the injured hospitalised? ☐ Yes ☐ No If yes, please provide a copy of the inpatient discharge summary.	
Did the injured attend any outpatient treatment after the accident? ☐ Yes ☐ No If yes, please provide name of hospital/clinic.	
How many days of Medical Leave was the injured given from the time of accident? (a) Hospitalisation Leave: _____ (b) Outpatient Leave: _____	
Has the injured returned to work? ☐ Yes ☐ No If yes, please advise when _____ If no, please provide the probable period of disablement _____	
Is the injured able to do partial work? ☐ Yes ☐ No	

EARNINGS OF INJURED WORKER

(GROSS MONTHLY EARNINGS DURING THE 12 MONTHS PRECEDING THE DATE OF ACCIDENT)

MONTH	NO. OF WORKING DAYS	GROSS MONTHLY EARNINGS (EXCLUDING BONUS)	ANNUAL WAGE SUPPLEMENT / BONUS PAID DURING LAST 12 MONTHS
TOTAL			
TOTAL MONTHLY AVERAGE			
TOTAL DAILY AVERAGE			

IMPORTANT NOTICE

1. Insured is requested to complete the form as fully and accurately as possible the information asked for as per above.

2. If any detail or information is not readily available, please do not delay the submission of this claim form and supply the missing detail or information as soon as possible.

3. Please submit the following:

   (a) Original Claim Form duly completed and signed;
   (b) Copy of i-report submitted to Ministry of Manpower;
   (c) Police report (if applicable);
   (d) Original medical bills/receipts and certificates;
   (e) Copy of NRIC/Passport/Work Permit (with photo shown);
   (f) Copies of detailed wage payment vouchers of the injured (12 months preceding the date of accident);
   (g) Copies of detailed wage payment vouchers during the period of Medical Leave;
   (h) Copy of death certificate, if the accident resulted in death of employee; and
   (i) Copies of all your correspondences exchanged between you and Ministry of Manpower and/or all third party correspondences.

4. According to the Work Injury Compensation Act, each and every accident occurred to your employee(s) at work must be reported to the Ministry of Manpower through i-report within 10 days of the occurrence of the accident:

   * where it results in death of an employee; or
   * where it renders an employee unfit for work for more than 3 consecutive days or hospitalised for at least 24 hours; or
   * where the employee has contracted an occupational disease.

   Failure to report a work-related accident is an offence which carries a fine of up to S$5,000 for a first-time offence and a fine up of up to S$10,000 and/or a jail term of up to 6 months for subsequent offences.

5. In the case of a fatal accident, please inform us the date, time and place of Coroner Inquiry when it is made known to you and provide us with a copy of death certificate and post mortem report respectively.

6. If the accident is a subject of claim under Common Law, please forward to HL Assurance Pte. Ltd. all correspondences that you have received, or may receive, from the lawyer(s) of injured and you must not, in any circumstances, admit liability whatsoever in any manner, be it verbal or in writing.

DECLARATION

AUTHORISATION FOR MEDICAL REPORT (TO BE COMPLETED BY THE INJURED WORKER)

I hereby authorise any hospital doctor or other person who has attended to me to furnish HL Assurance Pte. Ltd. or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription or treatment and copies of all hospital or medical records. I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

Name _____ Signature _____

NRIC/Passport/Work Permit No. _____ Date _____

I/We declare that the above information is true and correct to the best of my/our knowledge and belief, and I/we claim in respect thereof the protection of my/our policy. 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.

Insured's signature (with Company's stamp) _____ Name & Designation _____

NRIC/Passport No. _____ Date _____