ERGO

WORK INJURY CLAIM FORM

The insured is required to state as fully and accurately as possible the information asked for hereunder and to return this form immediately to the Company. The acceptance of this Form is not in itself an admission of liability on the part of the Company.

(A) EMPLOYER

Name of Insured ______________________

Address ______________________

Policy No ______________________ Phone No ______________________

Business/Occupation ______________________

Address ______________________

GST Resgistered? ☐ Yes ☐ No Is Yes, GST Registration No. ______________________

(B) INJURED PERSON (If work permit holder, please attach a copy to this form)

Name ______________________

Address ______________________

Passport/Fin/NRIC No. ______________________ Nationality ______________________

Race ______________________ Sex ____________ Age ____________

No. of days worked per week ______________________ Date of commenced employment ____________

Occupation for which the injured is employed ______________________

(a) Was the injured person engaged in your above stated occupation when the accident occurred? ☐ Yes ☐ No

(b) Was the injured person under the influence of drink or drugs at the time of the accident? ☐ Yes ☐ No

(c) Was he guilty of any misconduct or disobedience to orders or rules? ☐ Yes ☐ No

If so, please give particulars.

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(d) Is the injured person in your direct employ? ☐ Yes ☐ No

If not, please give

i) Name ______________________

ii) Address ______________________

iii) Relationship to you ______________________

(e) State clearly if the injured is casual or permanent or temporary or on loan to you ______________________

If on loan, from whom

i) Name ______________________

ii) Address ______________________

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(f) Has the accident been reported to the Commissioner of Labour? State date reported.
(Please attach a copy of the i-Report made to the Ministry of Labour).

(g) Was the injured person performing work on a contract/project undertaken by you?
If so, from whom

i) Name

ii) Address

(h) If the above (g) is Yes, please provide the name and address of the main contractor of the contract/project

i) Name

ii) Address

FOR FATAL ACCIDENT ONLY

Please give full particulars of the deceased's family. Kindly state names, addresses,relationships, age and occupation.
Please attach seperate sheet of paper if space is insufficient.

(a) Please forward Death Certificate and Post-mortem report(if any)

(b) Kindly state date, time and place of hearing of Death Inquiry

(C) PARTICULARS OF ACCIDENT

Date Time Place

(a) Detailed description of circumstances leading to the accident (Please attach a copy of the police report if one has been lodged.

(b) Nature of injury (e.g. laceration, burn, fracture, etc.) and the part of body injured.

(c) Through whose neglect did the accident occur?

Name ______________________ Occupation ______________________

Address ______________________

His/Her employer's name ______________________

His/Her employer's address ______________________

(d) Name(s), Address(es) of witness(es)

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(e) Please draw diagram below (in the case of accident involving vehicles or machinery)

If the accident was caused by machinery or gears:

Was it fenced or guarded? ______________________

Was it in motion? ______________________

(D) MEDICAL INFORMATION

(a) Where did the injured person receive medical treatment?

i) Name of hospital and/or Clinic ______________________

ii) Whether in-patient or out-patient ______________________

(b) Has the injured person return to work? ☐ Yes ☐ No

i) If so, when? ______________________

(c) Was the part of the body injured by the accident quite normal before the accident? If not, give full detail.

____

____

(d) Was the injured person free from physical infirmity or defect at the time of the accident? If not, please specify?

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(e) Would such physical infirmity or defect have contributed towards the accident?

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(E) 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 allowances, EPF or CPF contributions and special expenses incurred by reason only of the nature of employement) plus the value of all priviledges or benefits in kind, for food, fuel, quarters and any other which is capable of being estimated in money (except any travelling concession).

Months	TOTAL EARNINGS			
	Wages		Bonus, overtime, value of free quarters and any other allowances etc.	
	$	Cents	$	Cents
TOTAL				

*Please enclose payroll slip/payment vouchers

(F) THE DECLARATION

I/We certify that the foregoing is true and correct to the best of my belief.

______________________ ______________________

Date | Stamp and Signature of Employer

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(G) IMPORTANT NOTICE

1. According to the Work Injury Compensation Act, employers are required to report work related accidents to the Ministry of Manpower within the time stipulated below

What to report	Reporting time
a)Where the accident results in death of an employee	Within 10 days of the occurence
b)Where the accident results in any incapacity that renders the employee unfit for work for more than 3 consecutive days, or admitted in a hospital for at least 24 hours for observation or treatment	

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

2. When the injured person returns work, you are to send to the Company the following documents:-

   (a) Letter informing us of the date he returned to work.
   (b) Original Medical Certificates & bills & Assessment of Compensation issued by the Ministry of Manpower, when available,
   (c) All correspondences between you and the Ministry of Manpower, if any.

3. No claim for compensation will be considered unless the aforesaid documents mentioned in 2 (b) are produced.

4. If the accident is a subject of claim under Common Law, you are to forward to the Company all letters that you have received, or may receive, from the lawyers for the workman and you must not, in any circumstances, admit liability in any manner.

DATA PRIVACY STATEMENT

In accordance with the Personal Data Protection Act 2012, I/We consent to the collection, use, disclosure of and/or process my/our personal data (whether contained in the Claim Form or otherwise obtained) by ERGO Insurance Pte Ltd, its affiliates and service providers (within or outside Singapore), for the purpose relating to the evaluation of the claim and to provide advice and information relating to the claim to me/us by Mail, Email and fax messages (notwithstanding the registration of my/our telephone number(s) in the Singapore's Do Not Call Registry).

Yes, I/we have read and agreed to the above Data Privacy Statement.

Signature ______________________________

Name ______________________________

NRIC/Passport No. ______________________________

DECLARATION AND AUTHORIZATION

I/We hereby declared the foregoing answers to be true and correct in every respect to the best of knowledge and no information or particulars have been suppressed.

Signature of Insured(with company stamp)

Date (dd/mm/yyyy)