Claim Form – FMW AccidentProtect Insurance

Enhanced Accident and Hospitalisation Insurance for Foreign Migrant Workers

Important Notice: To enable us to process your claim, please submit the duly completed claim form with supporting documents in original as listed in Appendix 1 below. We reserve the right to request for additional information. All documentary proof or reports as required by ERGO shall be submitted at the expense of the Policyholder or Claimant. Please mail the claim form and all correspondence to:

Claims Department
ERGO Insurance Pte Ltd.
5 Temasek Boulevard,
#04-05 Suntec Tower Five,
Singapore 038985
Claims Service: (+65) 6829 9195 (Monday - Friday, excluding public holidays: 8.30 AM to 5.30 PM)
Claims Fax: (+65) 6829 9247
Claims Email: claims@ergo.com.sg
Submit claim online: https://ergo.com.sg/general-insurance-claim/

Please complete appropriate sections of this claim form based on the claim type with relevant information requested as accurate as possible. The issue and acceptance of this form does NOT constitute an admission of liability by ERGO Insurance Pte Ltd. or waiver of its rights.

Policy Number_____

Policyholder Information

Policyholders Full Name (as per Work Permit/ S Pass)	☐ Mr. ☐ Mrs. ☐ Ms.	Work Permit/ S Pass No.	
Nationality		Marital Status	☐ Single ☐ Married
Date of Birth	DD/MM/YYYY	Gender	☐ Male ☐ Female
Occupation		Date Employed	DD/MM/YYYY
Contact details in Singapore	Address _____ Residential _____ Mobile _____ Email _____@_____		
Contact details in Country of Origin	Address _____ Residential _____ Mobile _____ Email _____@_____		
No. of Dependent Children			

Claimant Information (☐ Same as Policyholder)

Claimant's Full Name (as per Passport)	☐ Mr. ☐ Mrs. ☐ Ms.	Passport No.	
Nationality		Marital Status	☐ Single ☐ Married
Date of Birth	DD/MM/YYYY	Gender	☐ Male ☐ Female
Contact details in Singapore	Address _____ Residential _____ Mobile _____ Email _____@_____		
Contact details in Country of Origin	Address _____ Residential _____ Mobile _____ Email _____@_____		
Relation to Policyholder			

To be completed by Agent/Broker (If Applicable)

Producer Code		Name of the Producer	.
Contact Person		Contact Number	
Mailing Address			
Email	_____@_____		
Preferred mode of communication	☐ Mail ☐ Email		

Cause of condition/disability suffered

☐ Accident	☐ Illness

Accident related claim

Date and time of Accident	DD/MM/YYYY HH:MM ☐ AM ☐ PM
Location of Accident	
Description of Accident	
Date of death	DD/MM/YYYY
Was the deceased insured in good health and free from physical defect or infirmity at the time of the Accident? ☐ Yes ☐ No	
Have you filed a police report?	☐ Yes ☐ No Date of report DD/MM/YYYY Police Station in which you filed the report _____ Were there witnesses to the incident? ☐ Yes ☐ No If Yes, please provide details of any witness of the incident
Witness Name	
Address	_____ _____Post Code_____

Please furnish the details of any hospitalization in connection with this Accident

Name of Hospital	Admission No.	Admission Date	Date Discharged	Type of Ward
		DD/MM/YYYY		
		DD/MM/YYYY		
		DD/MM/YYYY		
		DD/MM/YYYY		
		DD/MM/YYYY		
		DD/MM/YYYY		

Please furnish information on your first consultation	
Doctor Consulted Doctor's Contact No. Doctor's File Ref No. (if applicable)	Doctor's Address _____ _____Postal Code_____
Please furnish information of your regular doctor	
Regular Doctor Regular Doctor's Contact No. Doctor's File Ref No. (if applicable)	Regular Doctor's Address _____ _____Postal Code _____

Illness related claim

Employment Termination date (date of the letter of discharge issued by the Ministry of Manpower) DD/MM/YYYY
Description of Claim (answer wherever applicable)
Describe the symptoms suffered: _____ _____ _____ _____
Answer the questions pertaining to your condition stated above. a. Are there any symptoms which are or were evident for this condition? If yes, please advise the date of onset of the symptoms. DD / MM / YYYY b. Have you been recommended to receive or received treatment, advice or diagnosis for this condition? If yes, please advise the date of your 1st consultation. DD / MM / YYYY c. Please describe the symptoms you experienced. _____ _____ _____ _____

Please provide information on your first consultation.			
Doctor Consulted			
Doctor's Address			
Doctor's Contact No.		Doctor's File Ref No. (if applicable)	
Please provide information of your regular doctor.			
Family Doctor			
Family Doctor's Address			
Family/ Regular Doctor's Contact No.		Doctor's File Ref No. (if applicable)	

Please furnish the details of any hospitalization in connection with this illness				
Hospital Name	Admission No.	Type of Ward	Date of Admission	Date of Discharge
			(DD-MM-YYYY)	(DD-MM-YYYY)
			(DD-MM-YYYY)	(DD-MM-YYYY)
			(DD-MM-YYYY)	(DD-MM-YYYY)
			(DD-MM-YYYY)	(DD-MM-YYYY)
			(DD-MM-YYYY)	(DD-MM-YYYY)

Have any of your family members experienced this similar or related illness? If yes, please provide details.				
Relationship of Family Member	Nature of Illness	Date Diagnosed	If Deceased, Date	Age
		(DD-MM-YYYY)	(DD-MM-YYYY)	
		(DD-MM-YYYY)	(DD-MM-YYYY)	
		(DD-MM-YYYY)	(DD-MM-YYYY)	
		(DD-MM-YYYY)	(DD-MM-YYYY)	
		(DD-MM-YYYY)	(DD-MM-YYYY)	

Are there any other illness/complaints suffered by you prior to this event? If yes, please provide details:

Other claims

Child Support Fund

Please provide the details of the dependent children:

Full name of the child	Gender	Date of Birth	Education level
		DD/MM/YYYY	
		DD/MM/YYYY	
		DD/MM/YYYY	
		DD/MM/YYYY	

Family Funeral Benefit

Please state the name of the deceased and relationship to you:

Name: Date of Birth: DD/MM/YYYY Relationship:

Date and Time of Death: DD / MM / YYYY HH:MM

Details of your other insurance or compensation claims

Have you made a claim against any other party in respect of this event? If yes, please provide:

Name of Insurance Company/Other Party	Policy/Reference No.	Type of Benefit	Have you filed a claim?	Amount claimed

If the space provided is insufficient for your answer, please continue on a separate sheet.

Have your other claims been paid by the other policies above? ☐Yes ☐ No

Preferred mode of claim payment (☐ Bank transfer ☐Cheque)

Bank Account Details (for direct transfer to your bank account)			
Payee Name (as per bank account)			
Name of Bank		Bank Code	
Account No.		Branch Code	
Cheque made payable to			

Important Notice: ERGO shall:

1) Be discharged from all liability under this claim and
2) Not be liable for any and all losses incurred by you, as a result of you providing ERGO with an inaccurate account number under this section for payment of this claim.

Acknowledgement and Declaration

[Declaration] I/we declare that the particulars stated above are true, accurate and complete and I understand that if I have in this or in any further declaration in respect of this claim, made any false or fraudulent statement or suppress conceal or falsely state any material fact whatsoever my claim may be refused.

[Authorization] Where applicable, I/we hereby authorize any hospital, clinic, physician or any other person to disclose all information including copies of all hospital or medical records on the patient when requested by ERGO Insurance Pte Ltd. (ERGO). I have noted that any illness, injury, consultations, medical history, prescriptions or treatment the medical report fee incurred will be borne by me. A copy of this authorization shall be considered as effective and valid as the original.

[Personal Data Protection Statement] The Insured Person(s) understand, acknowledge, agree and consent that:

- ERGO Insurance Pte. Ltd. (ERGO) may/will collect, use, disclose and/or process the Insured Person(s) personal information set out in the proposal form and any other information provided by the Insured Person(s) or possessed by ERGO for the purpose of enabling ERGO to provide the Insured Person(s) with services required of an insurance provider, such as evaluating, processing, administering, and/or managing of the Insured Person(s) relationship and policies with ERGO. This includes among other things Policy servicing, processing, investigating, handling, administering and/or settling the Insured Person(s) claim with ERGO or other insurers;
- ERGO may/will disclose and transfer the Insured Person(s) personal information to third parties, including but not limited to its affiliates, representatives, agents and third party service providers, lawyers/law firms, whether located within or outside Singapore, for one or more of the above purposes, and the said third parties may/will subsequently collect, use, disclose and/or process the Insured Person(s) personal information for one or more of the above purposes;
- If personal information of third parties (e.g. information of Insured Persons, beneficiaries, beneficial owners, dependents, customers, payees and/or employees) is provided to ERGO, the provider of such personal information represents and warrants to ERGO that prior consents have been obtained from each of the third parties to provide such information.

  Note: Please refer to the full version of Our Data Privacy Policy found at https://www.ergo.com.sg/pdpa.

Signature of Claimant: _____ Date Signed: DD / MM / YYYY

Signature of Policyholder: _____ Date Signed: DD / MM / YYYY

Name	Company Stamp
Designation	

Medical Information form (to be completed by attending physician)

Name of Patient:		**Work Permit/ S Pass No.**
Date when the Patient first consulted you: _____	**Prior to the first consultation with you, when did the Patient first suffer the symptoms of the condition:** _____ _____	
Presenting Complaints:	_____ _____	
Was the Patient referred by another physician? If Yes, please state: _____		☐ Yes ☐ No
Name of Physician:		**Contact No.:**
Mailing Address: _____Postal Code _____		
State your diagnosis of the illness/injuries:		
Details of Surgical Operation(s)/Procedure(s) done:		
Date of Admission:		**Date of Discharge:**
Is there any connection between the present condition and any other pre-existing illness or previous accident? If Yes, please give details: _____		☐ Yes ☐ No
Is the Condition of the Patient: Hereditary or Congenital in nature Psychological/Mental Condition Self-inflicted injury Attempted Suicide Sexually transmitted disease Related to cosmetic treatment Infertility related Pregnancy related Drug/Alcohol related	 ☐Yes ☐Yes ☐Yes ☐Yes ☐Yes ☐Yes ☐Yes ☐Yes ☐Yes	 ☐No ☐No ☐No ☐No ☐No ☐No ☐No ☐No ☐No
If any of the above is Yes, please provide details:		
Is the Condition of the Patient related to an Accident? If Yes, please provide details of the Accident, whether it is work-related and if police report was made? _____		☐ Yes ☐ No
Will illness/injury require further follow-up treatment? If Yes, please provide details: _____		☐ Yes ☐ No
Any other relevant information:		

Please furnish copies of all the reports/investigations results.
I hereby certify that I have personally examined and treated the Patient for the above illness/injuries and that the facts as given above present my opinion of the Patient's condition.

_____
Date

_____
Signature of Physician
Name
Contact Number
Stamp

Appendix 1: - Supporting documents

The below supporting documents which have been marked must be enclosed with the claim form.		
Accidental Death:		
1) For death in Singapore	☐	Copy of death certificate
2) For death outside Singapore	☐	- Certified true copy of death certificate by your lawyer or any notary public - Repatriation report (if the body was sent home to the Country of Origin for cremation or burial)
3)	☐	Autopsy report, toxicological report or coroner's findings
4)	☐	Proof of policyholder's or claimant's relationship to the person who died Policyholder or Person claiming / Documents needed Husband or wife / Marriage certificate Parent / Birth certificate of person who has died Child / Birth certificate of policyholder or person claiming Brother or sister / Birth certificates of person who died and policyholder or person claiming
5)	☐	Newspaper clipping and police or accident report (if death was due to accidental or violent causes)
6)	☐	Last will of deceased (if they had left a will) or letter of administration (if there is no will)
7)	☐	Estate duty certificate
8)	☐	Police report and findings on the alleged accident (if applicable)
9)	☐	Copy of driver's licence and certificate of auto insurance (if deceased was driving at the time of accident)
10)	☐	Incident report lodged by the employer (if the accident is industrial or work related)
Hospital and Surgical In-patient (Applicable in the country of origin only):		
1)	☐	Letter of discharge issued by the Ministry of Manpower
2)	☐	Medical report – (Attending doctor to complete the attached medical information form)
3)	☐	Medical reports or laboratory reports or inpatient discharge summary (stating clearly the start date, cause, extent of permanent disability (if this applies) and nature of injury or illness)
4)	☐	For a stay in hospital (if this applies and the claim is eligible) - Original final hospital bill and receipt of payment
5)	☐	For outpatient treatment (if this applies and the claim is eligible) – Original itemised medical bill and receipt of payment
6)	☐	Newspaper clipping and police or accident report
7)	☐	If items 3 and 4 have been given to another insurer or employer, please provide: (a) a certified true copy of the bills by the insurer or employer; (b) a reimbursement letter or payslip reflecting the co-payment by the insured or the employer; or (c) a discharge voucher or settlement advice by the insurer
Special Grant - death by any cause (excluding natural death):		
	☐	Same as Death claim above
Child Support Fund:		
	☐	Same as Death claim above
Family Funeral Benefit:		
1)	☐	Certified true copy of the Insured Person's ID card.
2)	☐	Copy of the death certificate of the Insured Person's spouse, child, or parents along with the proof of relationship with the Insured Person.
3)	☐	Additional documents or evidence as required by the Company (if any).

This is not a full list and we may ask for other documents.

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