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Claims Form – Work Injury Compensation

Document(s) for submission of claims to Liberty Insurance Pte Ltd

Document Required	Attached
1. Claim Form – (Did accident arise out of and in the course of employment?) 2. I-Report (if accident results in more than 3 days MC/hospitalisation for more than 24 hours/death) 3. Work Permit/Employee Pass (for foreign worker) 4. Copy of medical report (if available) 5. Inpatient Discharge Summary 6. Original medical bills and medical leave certificates 7. Copies of wage payment vouchers for 12 months prior to date of accident (e.g. accident in January 2019, require wage payment voucher for January 2018 to December 2018) 8. Please indicate the number of work days per week under "Earnings of Insured Worker" of the enclosed Claim Form 9. Contract (with value) for job accident site (where accident site is not insured premises) 10. Contractual agreement between main contractor and sub-contractor (for project policy) 11. Annual WICA policy of the other party (main/sub-con) insurer covering accident at worksite (for project policy) 12. Police report (where serious accident occurs resulting in fire, explosion collapse of building, etc) 13. Traffic police report (where it is a road traffic accident) 14. Death certificate and relevant reports (where accident results in death) 15. Timesheet/Attendance/Work Schedule for the month of accident 16. Copy of Toolbox Meeting (if applicable)	

Note: Additional documents may be requested as and when necessary

Claims Form – Work Injury Compensation

Please complete all sections to facilitate the processing of your application. This form is issued without admission of liability and it must be completed and returned to us immediately, whether or not a claim is made. Any documentary proof or report required by Liberty shall be furnished at the expense of Policyholder or Claimant.

Information of Policyholder

Name of Policyholder: _____		Policy No.: _____
Mailing Address: _____		Postal Code ( )
Email: _____		Contact No.: _____
Name of Main Contractor (if Policyholder is not the main contractor) for this project: _____		Nature of Business: _____
Total No. of Employees: _____	Name of Insurer(s): _____	Policy No.: _____

Details of Injured Employee

Name of the Injured Employee: _____		NRIC/FIN No. of Injured Employee: _____
Mailing Address of Injured Employee: _____		Postal Code ( )
Contact No. of Injured Employee: _____	Age of Injured Employee: _____	Citizenship of Injured Employee: _____
Marital Status of Injured Employee: Please select	Gender of Injured Employee: Please select	Date Entered Service of Injured Employee: _____
Occupation of Injured Employee: _____		
Was the worker engaged in the occupation when the accident occurred? If No, please provide details: _____		Please select
Is there any other policy(ies) covering the worker in respect of this accident? If No, please provide details: _____		Please select

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Is the worker your direct employee? Please select
If No, please provide details of direct employer:

Name of Direct Employer: Contact No. of Direct Employer:

_____ _____

Mailing Address of Direct Employer:

_____ Postal Code ( )

Details of Accident

Date of Accident:	Time of Accident:	Place of Accident:
_____	_____	_____

Address of Accident:

_____ Postal Code ( )

Date that the accident was reported to you (if in writing, attach correspondence):

_____

Was the worker injured due to his/her misconduct or failure to follow instructions? Please select
If Yes, please provide details:

_____

Was anyone supervising the employee at the time of the accident? Please select
If Yes, please provide details:

_____

Describe how the accident occurred:

_____

Name of Supervisor: Designation of Supervisor:

_____ _____

Mailing Address of Supervisor:

_____ Postal Code ( )

Contact No. of Supervisor:

_____

Was the accident reported to the Ministry of Manpower (MOM)? (Attach a copy of the MOM i-Report) Please select
If Yes, date reported:

_____

Claims Form – Work Injury Compensation

If the claim is reported too late, please provide the reason:

_____

Responsibility/Witness (es)

Was another person, in your opinion, responsible for the accident? Please select
If Yes, please provide details:

Name: NRIC/FIN No.:

_____ _____

Home Address:

_____ Postal Code ( )

Office Address:

_____ Postal Code ( )

Reason(s) why he/she was responsible:

_____

Was there a witness(es) to this event? Please select
If Yes, please provide details:

Name of Witness: NRIC/FIN No. of Witness:

_____ _____

Home Address of Witness:

_____ Postal Code ( )

Office Address of Witness:

_____ Postal Code ( )

Occupation of Witness: Contact No. of Witness:

_____ _____

Injuries Sustained from the Accident

Details of the injuries, including the nature and region:	Date of when the worker ceased work:
_____	_____
Name of Hospital/Clinic that the worker was treated:	Date of discharged from hospital:
_____	_____

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Is the worker still undergoing medical treatment? If No, when is the worker likely to be able to return to work? _____	Please select
Are there any more medical bills or medical leave certificate forthcoming?	Please select

In Death cases, please furnish:
a) A copy of the Death Certificate, post mortem report and police report (if any)
b) List of Deceased's dependants, stating names, addresses, ages, relationships and occupations
c) Date of the coroner's inquire, if any

Earnings of Injured Worker

The "Earnings" of an injured workman include his wages, food allowance, housing allowance, overtime, bonus or annual wage supplement but do not include travelling allowance, employer's share of the CPF contributions or pension or money paid to cover any special expenses incurred by him by nature of his employment.

No. of Working Days per Week:

Please select

Month	Gross Monthly Earning (excluding bonuses)	Annual Wage Supplement
	S$	S$
	S$	S$
	S$	S$
	S$	S$
	S$	S$
	S$	S$
	S$	S$
	S$	S$
	S$	S$
	S$	S$
	S$	S$
	S$	S$
Total Average	A1 S$ 0.00	A2 S$ 0.00
Total Average Earnings (A1 + A2)	0.00	

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Bank Account Information for Electronic Transfer

Name of Bank:	Bank Code:	Branch Code:
_____	_____	_____
Bank Account No.:	**Name of Bank Account Holder:**	
_____	_____	

I agree to hold Liberty Insurance Pte Ltd harmless and that it is fully and finally discharged of its obligations once it has made payment to the bank and bank account number given above.

DECLARATION

a) I declare that I have complied with the conditions and warranties (if any) of the policy and in no manner deliberately caused the said loss or damage or exaggerated the claim or sought unjustly to benefit by any fraud or willful misrepresentation and that the information shown on this Form is true and that I have not concealed any information relating to this claim. I understand Liberty Insurance reserves the right to repudiate the claim if it is later proven false or intentionally omitted by me.

b) I authorise the release of any medical information necessary to process this claim.

c) I/We have read & agreed entirely to all terms in Liberty's Data Protection Policy, available on request & also at www.libertyinsurance.com.sg/data-protection-policy, both now & in advance as it may be amended from time to time.

_____ _____

Date Signature of Claimant

_____ _____

Date Signature of Policyholder
(Company stamp, if applicable)

Submit