FOREIGN WORKER MEDICAL (FWM)
CLAIM FORM

Agency/Broker: _____

FWM Policy No.: _____

IMPORTANT

1. This form is issued and/or accepted without admission of liability.
2. The insured must complete this form fully and accurately.
3. The list of documents required is not exhaustive and we reserve the right to request from you any additional information/documentation, as necessary.

1. Particulars of Insured

Name of Insured (Company)				GST Registered :	◯ Yes ◉ No
				GST No. *(if Yes)*	
Company Address				Date of Enrolment/Cover	
Contact Person				Nature of Business	
Contact No.				Email	
HP		O			
Name of Main Contractor (if applicable)			Name of Sub-Contractor *(i.e. direct employer) (if applicable)*		
Name of Person who lodged report (As in NRIC/Passport)				NRIC/Passport/WP/FIN No.	
Contact No.			Total No. of Employees	Occupation	
HP		O			

2. Details of Injured Person

Name *(as in NRIC/Passport)*				NRIC/Passport/WP/FIN No.
(a) Local Residential Address				Date of Birth *(dd/mm/yyyy)*
				sdfgsd
(b) Residential Address in your Home Country				Nationality
Gender		Date of Employment		Occupation
◉ Male ◯ Female				
Contact No. (H)	(O)		(HP)	Email

3. Details of Illness or Injury

A) HOSPITALISATION DUE TO ILLNESS

Name of Hospital			
Date of symptoms first appeared *(dd/mm/yyyy)*		Hospital Admission Date *(dd/mm/yyyy)*	
Date of Surgery Performed *(dd/mm/yyyy)*		Hospital Discharge Date *(dd/mm/yyyy)*	
Has the illness been treated previously?	◯ Yes ◉ No	*If Yes, Name & Address Of Physician and Date of First Treatment*	
Diagnosis & Symptoms			

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Types of Surgery performed *(if applicable)*				
Is this illness work-related?	◯ Yes	◉ No	*(If Yes, please provide details below)*	
Is the illness due to pregnancy, abortion, miscarriage, sterilization or infertility?	◯ Yes	◉ No	◯ Not Applicable	
If Yes, please specify condition & approximate date of discovery?				
Date of last pregnancy, *if applicable*:				
Are there any known pre-existing conditions when the employee was employed?	◯ Yes	◉ No	*If Yes, please provide details*	
Any post hospitalization treatment required?	◯ Yes	◉ No		
B) HOSPITALISATION DUE TO INJURY FROM ACCIDENT				
Name of Hospital:				
Date/Time of Accident		Hospital Admission Date *(dd/mm/yyyy)*		
Date of Surgery Performed *(dd/mm/yyyy)*		Hospital Discharge Date *(dd/mm/yyyy)*		
Place of Accident				
Is this a work-related injury?	◯ Yes	◉ No		
Describe how it happened and state the extent of the injury				
Are there any known pre-existing conditions when the employee was employed?	◯ Yes	◉ No	*If Yes, please provide details*	
Any post hospitalization treatment required?	◯ Yes	◉ No		
C) OTHER INSURANCE OR COMPENSATION				
Is it claimable under Work Injury Compensation?	◯ Yes	◉ No		
Are you making a claim from any other insurance companies?	◯ Yes	◉ No	*If Yes, please provide information below*	
Name of Insurance Company				
Type of Policy				
Policy No.				

REMARKS:

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DECLARATION

i. I declare that the above statements and answers are true and complete to the best of my knowledge and belief.
ii. I hereby authorize any hospital, physician, person or organization to disclose when requested to do so by ECICS Limited, all information with respect to any illness, injury, medical history, consultations, prescription or treatments and copies of all hospital or medical records.
iii. A photocopy of this authorization shall be considered as effective and valid as the original.

NOTICE: Personal Data Protection Policy

We/I understand, acknowledge, agree and consent that:

a) ECICS Limited (the "Insurer") is permitted to collect, use, disclose and/or process my personal data/personal information set out in this Claim Form and any other personal information provided by me or possessed by ECICS Limited (collectively the "Personal Information") and disclose and transfer such Personal Information to the Insurers' lawyers/law firms, Insurers' doctors, the Monetary Authority of Singapore and any relevant government agency/authority (such as the police), for the purpose(s) of:

(i) processing, handling and/or dealing with my claims including the settlement of the claims and any necessary
(ii) investigations relating to the claims;
(iii) investigating my claims
(iv) carrying out and/or dealing with my instructions or responding to any enquiries by me;
(v) administering my claims (including the mailing of correspondence, statements, invoices, reports or notices to me, which could involve disclosure of certain personal data about me to bring about delivery of the same as well as on the external cover of envelopes/mail packages); and/or
(vi) complying with applicable law in administering, processing, handling and/or dealing with my claims.

(collectively the "Purposes")

b) the Insurers' lawyers/law firms, insurer's doctors, adjuster may/are permitted to collect, use, disclose and/or process my Personal Information for one or more of the above Purposes; and

c) my Personal Information may/can be disclosed by any of the Insurers and/or GIA to their third party service providers or agents (including their lawyers/law firms), which may be sited outside Singapore, for one or more of the above Purposes.

Note: ECICS Limited Privacy Policy can be found at http://www.ecics.com.sg/pers.htm

Signature of Insured Person/Employee	Signature of Employer/Company's Stamp
Date:	Date:

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