PERSONAL ACCIDENT (PA) CLAIM FORM

Agency/Broker: _____

PA 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. (HP)	(O)		Email	
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. (HP)	(O)	Total No. of Employees	Occupation	

2. Particulars of Injured Person

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

3. Details of Accident

Date/Time of Accident		Place of Accident	
Was the injured person drunk or under drugs at the time of the accident?	○ Yes ○ No	Will there be any more bills to be submitted?	○ Yes ○ No
Details of how accident occurred and what the injured person was doing at that time *(attach accident report for our references)*			
Nature and Extent of injury sustained *(including type of injury and part of the body injured)*			

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Name and address of any witness(es)			
Date Returned/Expected to return to work *(dd/mm/yyyy)*			
Is this a job-related accident?			◯Yes ◯No
Has the injured person previously suffered from an injury to the same part? If Yes, please give details			◯Yes ◯No
If still receiving treatment, please state nature of treatment and next date of scheduled medical appointments			
Death *(if applicable)* In what capacity are you claiming the insurance? Please state your relationship with the deceased.			
Any surgical operation performed? *If Yes, please state below*			◯Yes ◯No
Hospital Admission Date *(dd/mm/yyyy)*		Name of Hospital Admitted	
Hospital Discharge Date *(dd/mm/yyyy)*			
Date Surgery Performed *(dd/mm/yyyy)*		Class of Ward	
Surgery Details *(Please provide details on surgery performed and attach "ATTENDING PHYSICIAN'S STATEMENT" for our review)*			
What is the estimated period of incapacity?			

OTHER INSURANCE OR COMPENSATION

Is the injured person presently also insured for medical insurance under another Insurance Company?	◯Yes ◯No
If Yes, please provide information below: Name of Insurance Company Type of Policy Policy No.	

Documents to be submitted	☐ Attending Physician's Statement
	☐ Original Invoice & Receipt
	☐ Inpatient Discharge Summary
	☐ Medical Report
	☐ Police Report
	☐ Death Certification / Letter of Administration
	☐ Medical Certificate
	☐ Copy of Patient's Passport/Work Permit/Identity Card
	☐ Coroner's Findings/Post Mortem Report/Toxicological Report

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. I authorize to disclose information (including health information) about the insured person if this claim is made on behalf of them.
iv. 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 Policyholder	Signature of Patient
Date:	Date:

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