Great Eastern General Insurance Limited (Reg. No. 192000003W)
1 Pickering Street, #01-01 Great Eastern Centre, Singapore 048659
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greateasterngeneral.com

WORK INJURY COMPENSATION INSURANCE CLAIM FORM

Agency: _____ Contact No.: _____ Email Address: _____

1. Full particulars of the accident are to be furnished by the employer described in this form.
2. The giving of the undermentioned information does not imply that the injured person is making, or will make, a claim.
3. This form is sent without prejudice to the terms of the policy described in this form.
4. This form is to be completed and forwarded without delay. Any details of information not readily available may be supplied as soon as obtainable.
5. All written communications received by the employer concerning the accident to its employee should be forwarded at once to Great Eastern General Insurance Limited ("Company").

THE EMPLOYER

Name of Insured: _____ Policy No: _____

Business: _____ Contact No.: _____ Email: _____

Address: _____

_____

THE INJURED EMPLOYEE

Name: _____ Nationality: _____ Date of Birth: _____ Gender: _____

Local Address: _____

Date of Employment (dd/mm/yyyy): _____

Occupation of Injured: _____

Was the injured person engaged in the above occupation when the accident occurred? _____

Name of hospital taken to: _____ In or out-patient: _____

State whether returned to work, and if so, when? _____

Indicate the number of working days per week: ☐ 5 days ☐ 5.5 days ☐ 6 days
☐ Alternate Saturday ☐ Others: _____

Is the injured person able to do partial work? _____

What is the probable period of disablement (approximate)? _____

_____

THE ACCIDENT

Date: _____ Time: _____ Place: _____

On what date did the injured person actually cease work? _____

Explain in details exactly how the accident happened, specify the tasks and operation involved.

_____

_____

Where amputation is involved, please state precisely at which phalanx/part was amputated and state left or right side

_____

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

Was he/she guilty of any misconduct or disobedience to orders or rules? If yes, please elaborate.

_____

State through whose neglect the accident occurred, if any: _____

State the name of any persons who witnessed the accident: _____

Has the accident been reported to the Commissioner for Labour and Police? State when and where

_____

Statement of wages of the Injured Person earned **IN THE PRESENT EMPLOYMENT** for twelve months immediately prior to the date of this Accident, or wages earned during such shorter period as he/she may have been in the Employer's service, stating the date on which he/she was engaged.

Note:- The object of this form is to ascertain the **exact Monthly earnings** of the injured person and should be correctly filled in. **If the injured person has been absent from work at any time** during the period of his/her employment, please state the period and the cause.

YEAR	MONTH	WAGE		Bonus, Value of Free Quarters & any other Allowances	
		$	cts	$	cts
	TOTAL				
		Total including all allowances			

MODE OF PAYMENT

PayNow is the default settlement option up to S$200,000 for Insured who has registered with PayNow and has linked to the Unique Entity Number (UEN) to the bank account ("PayNow Account"). You hereby authorize and instruct The Company to deposit the payment that is payable to you into your PayNow Account as well as verify your PayNow Account with the respective Bank ("where necessary").

☐ PayNow				
Name of Account Holder:				
PayNow UEN number (for Corporate)			PayNow NRIC Number (for Individual)	
☐ Direct credit into your bank account. Please provide supporting documents such as bank statement for verification of payee details.				
Name of Bank	Bank Code	Branch Code	Bank Account Number	Account Holder's Name

DECLARATION AND CONSENT

I/We hereby declare that the particulars and information stated above are true and correct in every details and I/we agree that if I/we have made or in any further declaration in respect of the same claim shall make any false or fraudulent statements or suppress conceal or falsely state any material fact whatsoever the relevant insurance policies shall be void and all rights to recover thereunder in respect of past or future claims shall be forfeited.

Without prejudice to the consent given below in respect of my/our personal data, I/we hereby authorize any hospital physician, other person who has attended or examined me/us, and other insurers to furnish to the Company, or its authorized representatives, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A copy of this authorization shall be considered as effective and valid as the original.

PERSONAL DATA

In addition to the declaration and authorization provided above, I/we agree and consent to the Company, its related corporations (collectively, the "Companies"), as well as their respective representatives and agents collecting, using, disclosing and sharing amongst themselves my/our personal data, and disclosing such personal data to the Companies' authorised service providers and relevant third parties for purposes reasonably required by the Companies to evaluate, admit, process and/or administer my/our claims.

The purpose are set out in Great Eastern's Privacy Statement, which is accessible at https://www.greateasternlife.com/sg/en/privacy-and-security-policy.html and which I/we confirm I/we have read and understood.

Signature of Employer: _____ Company's Stamp: _____ _____

Name: _____ Designation: _____

Date: _____

SUPPORTING DOCUMENT REQUIRED

- ☐ Duly completed and signed claim form
- ☐ Copy of I-Report lodged with MOM
- ☐ Photocopy of NRIC/Work Permit and Passport
- ☐ Injured pay history with wage payment vouchers for the past 12 months prior to accident
- ☐ Injured pay slips / vouchers for the medical leave period
- ☐ Medical bills
- ☐ Medical certificates
- ☐ After Visit Summary (treatment at A&E) / Inpatient Discharge Summary (Admission) / Memorandum from doctor
- ☐ Doctor's referral letter or doctor's memo if there is a change of clinic / hospital (subject to MOM's approval)
  Eg) Clinic / Polyclinic to A&E | A&E to Clinic/Polyclinic | Clinic to Clinic | Public Hospital to Public Hospital | Public Hospital to Private Hospital and vice versa.
- ☐ Any other documents such as police report, internal incident report or investigation report etc

Please note that the list above is not exhaustive and we may request for additional information/document(s) in the course of our claim review.