**Income Insurance Limited** | UEN: 202135698W
Income Centre 75 Bras Basah Road Singapore 189557
Tel: 6788 1777 · Fax: 6338 1500
Enquiries: www.income.com.sg/enquiry

# Work injury compensation claim form

**Important notice**

- If we accept this form, this does not mean we are taking legal responsibility for your claim.
- If we ask for any documents as proof or a report, you will have to pay the costs involved in providing them.
- To avoid delay in processing your claim, please submit your completed form, together with the supporting documents, within 30 days from the date of the event.
- Please do not leave any answer blank. Write 'none' or 'NA' where relevant.

| | |
|---|---|
| **Policy number:** | P-123456, P-987654 |
| **Claim number:** (For official use) | |

## Personal details of insured

| | | |
|---|---|---|
| Name of company | | Nature of business |
| Address of company | | Total number of employees<br>05092025 |
| Contact number<br>(Office) (Home) (Handphone) | | Number of workmen |
| Is your Company/Business GST registered? | GST registration number | UEN Number |

## Personal details of injured worker

| | | | |
|---|---|---|---|
| Full name of worker (as shown in NRIC/Passport)<br>Tan Wei Ming | Gender<br>☐ Male ☐ Female | NRIC or FIN number | Date of birth(dd/mm/yyyy)<br>15061992 |
| Address | | Citizenship | |
| Occupation | Marital status ☐ Single ☐ Married ☐ Widowed ☐ Divorced | Date worker joined service (dd/mm/yyyy) | |

Is the worker under your direct employment? If not, please give the name and address of his direct employer. ☐ Yes ☐ No

## Payee's details

**With immediate effect, we will ONLY make payment via direct transfer to Policyholder's bank account. Please indicate the bank details below clearly for us to process the payment and to avoid any delay to the claim settlement. Please tick √ the claim payment mode.**

☐ For payment by direct transfer into your bank account. Please provide supporting documents such as bank statement for verification of payee details.

| | | |
|---|---|---|
| Full name of payee (as shown in the bank account) | Name of Bank<br>DBS Bank | Bank Account Number |

☐ For payment by PayNow Individual or PayNow Corporate

PayNow NRIC or FIN number (for individual)/PayNow UEN number (for corporate)

## Accident details (please complete all questions)

| | | | |
|---|---|---|---|
| Date of accident (dd/mm/yyyy)<br>20082025 | Place | Date you were informed of accident (dd/mm/yyyy) | Date of admission (dd/mm/yyyy)<br>01012024 |

1. Please give detailed account of the accident.

2. If accident occurred at a project worksite, please report the accident to the Main Contractor & provide us with the following:

   (a) Name of the Main Contractor and details of the Project
   05092025

(b) Name of the Main Contractor's project Insur

05092025

3. Please give names of the persons who witnessed the accident.

4. Please give details of injury sustained (state injured body part and nature of injury).

Employer group coverage submitted

5. State the name of hospital/clinic where injured worker received treatment.

6. If hospitalised, please state whether still in hospital or when discharged. Is follow-up treatment required?

7. Has the worker returned to work? ( If so, to state the date of return)

05092025

8. State the probable period of his disablement.

9. Has the Commissioner for Labour been notified of this accident? ☐ Yes ☐ No

10. Please furnish the worker's gross monthly earnings during the 12 months preceding the date of accident:

| Month | Gross Monthly Earnings | Annual Wage Supplement/Bonus Paid During Last 12 months |
|---|---|---|
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| | | |
| | | |
| | | |
| **Total** | 05092025 | 05092025 |
| **Average** | | |

11. No of work days per week

☐ 5 days ☐ 5½ days ☐ 6 days ☐ Others False

## Personal data use statement

By providing the information and submitting this application or transaction, I/we consent and agree to Income Insurance Limited ("Income"), its representatives, agents, relevant third parties, Income's appointed insurance intermediaries and their respective third party service providers and representatives (collectively "Income Parties") (referred to in Income's Privacy Policy at http://www.income.com.sg/privacy-policy) to collect, use, and disclose any personal data in this form or obtained from other sources, including existing personal data provided and any future updates, (collectively "personal data") for the purposes of processing and administering my/our insurance application or transaction, managing my/our relationship and policies with Income including providing me/us with financial advice/ financial planning services, sending me/us corporate communication and information on products and/or services related to my/our ongoing relationship with Income, conducting consumer profiling/data analytic/research, which includes data matching based on personal data collected by Income, its affiliates, business partners and/ or NTUC Enterprise group of social enterprises ("NE Group") where required for Income, its affiliates, business partners and/or NE Group, to develop, improve and/ or customise their products/ services and/ or to provide you with their respective products /services, and in the manner and for other purposes described in Income's Privacy Policy.

Where the personal data of another person(s) (for example, personal data of my family, employee, payee/payer or beneficiary) is provided by me/us or from other sources to Income Parties, I/we represent and warrant that:

- I/we have obtained their consent for the collection, disclosure and use of their personal data; and
- I am/we are authorised to give any authorisation, approval and consent on their behalf to collect, use or disclose, their personal data,

for the purposes as set out in this Personal Data Use Statement.

For the purpose of this application and any claim in connection with my/our policy(ies) with Income, I/we also authorise, agree and consent to (whether this application or transaction is accepted or refused) the following:

a) The medical source, insurance office, reinsurer, or organisation to release to Income any medical or relevant information to do with me or the insured;
b) Income to collect from and/or disclose to any medical source, insurance office, reinsurer, or organisation any medical or relevant information to do with me or the insured; and
c) Income or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests for Income to underwrite and evaluate me or the insured health status or condition in relation to this application and any claim in connection with my/our policy(ies) with Income.

When submitting a claim for an insurance policy, I/we consent and agree that the personal data will also include any subsequent information collected on health or any information that is necessary for Income to decide whether to pay the claim, such as test results, medical examination results, and health records from medical sources such as medical examiners or laboratories.

I/We authorise, consent and agree to the following:

- Income Parties to collect from and/or disclose to the group policyholder, the personal data for all the relevant purposes listed above and in Income's Privacy Policy including to respond to enquiries from the group policyholder for the purposes of this application and policy servicing matters, including confirmation of eligibility for the cover; and
- The group policyholder to disclose the personal data to Income Parties for all the relevant purposes listed above and in Income's Privacy Policy.

Please refer to Income's Privacy Policy for more information, including access and correction of my personal data and consent withdrawal.

## Declaration and authorisation

I certify that the information in this form is true and complete and I have not withheld any material information.

I confirm that I understand and agree to the collection, use and disclosure of my personal data as stated in the 'Personal Data Use Statement'(PDUS) above.

For the purposes of policy administration including processing and investigating this claim, and deciding whether Income is to insure or continue to insure me for my insurance applications or policies,

a. I authorise any person or organization who has relevant information pertaining to this claim, including any medical practitioner, health care provider or institution, insurance company, and investigative agencies, to release and exchange such information (including personal health information) requested by Income and/or its claims service providers.
b. I authorise Income and its claims service providers to collect, use, disclose and to exchange with the persons or organizations listed above any information (including personal health information).
c. I am authorised to disclose information (including personal health information) about the insured person if this claim is made on behalf of them.

I confirm that all documents submitted to Income including bills and invoices are copy of the original documents and I am aware that I am required to retain all original documents for a period of 6 months from claim submission date for verification by Income when required. I am aware that Income may reject my claim should it discover that the document(s) that I have submitted is not a copy of the original document(s).

I confirm that I have paid in full all the bill(s)/invoice(s) that I have submitted to Income for reimbursement and I have not made any claim and will not make any claim from any other source for the same bill(s)/invoice(s). If I have made a claim from other source, I agree that I will provide a copy of the settlement agreement between me and such other source. I am aware that Income will not reimburse me if I have received a full reimbursement from any other source. If I do not receive full reimbursement from other source, I am aware and understand that Income will only reimburse me the balance of the bill/invoice that has not been paid to me by other source. In the event Income has made a reimbursement to me and I have claimed from other sources and be reimbursed for more than what I incurred in total, I agree that Income has the right to recover any payment made by Income to me.

I agree that a photocopy or electronic version of this authorisation shall be as valid as the original.

Authorised signature & company stamp: _____

Name of authorised signatory: 05092025

NRIC number: _____

Designation: _____

Date (dd/mm/yyyy): 30092025

Signature of injured worker: _____

Name of injured worker: _____

NRIC/Fin number: S1234567A

Date (dd/mm/yyyy): 30092025

**You may email the completed claim form and supporting documents to clineclaims@income.com.sg. Please be reminded to keep the original documents for 6 months as we may request for them on case by case basis prior to settlement of the claim.**

# Supporting documents

The below documents which have been **marked** will be enclosed with the claim form.

- ☐ **Traffic accident report**
- ☐ **Report(s) lodged with Ministry of Manpower**
- ☐ **Original medical bills & receipts**
- ☐ **Medical leave certificates**
- ☐ **Work permit (applicable for foreign workers)**
- ☐ **Contract/invoice for the project/works if you are a sub-contractor or are insured under the business policy**

Please arrange to submit the necessary documents listed above. We also wish to inform you that all necessary documents must be submitted with the claim form to enable your claim to be processed expeditiously. Please note that the list of documents is not exhaustive. Other documents may be requested if necessary.