FEDERAL INSURANCE COMPANY

One of the Chubb Group of Insurance Companies

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Unique Entity No. S83FC3361G

STANDARD PERSONAL ACCIDENT & MEDICAL EXPENSES CLAIM FORM©

The Insured is requested to state as fully and as accurately as possible the information asked for hereunder in order to expedite claim processing and to return the form immediately to the Company. Any documentary proof or reports required by the Company shall be furnished at the expense of the Policyholder or Claimant. Acceptance of this Form is not in itself and admission of liability on the part of the Company.

A. POLICYHOLDER / CLAIMANT

1. Policyholder _____ Policy No. _____
2. Address _____
3. Tel / Mobile _____ Email _____
4. Employee/Claimant _____ Age _____ Sex F ☐ M ☐
5. NRIC / Passport No. _____ Marital Status _____
6. Occupation _____ No. of Children / Ages _____ / _____
7. Commencement date of employment _____ Tel / Mobile _____

   If employed less than 12 months, state name of prior medical insurer, if any/known:

   _____

8. Country of Posting *(if applicable)* _____ Home Country _____ Date of Posting _____
9. Insured Person *(if not Employee/Claimant)* _____ NRIC/ Passport No. _____ Age _____ Relationship to Employee _____
10. Insured Person's prior medical insurer, if insured less than 12 months under this policy _____
11. Are there any other insurance which would cover this loss? Yes ☐ No ☐ *If yes, tick box if claim was submitted to them:* ☐
    Name of Insurance Company & Policy No.

    _____

B. DETAILS OF INCIDENT

1. Date and Time: _____ 2. Place: _____
3. If claiming Medical Expenses, please state diagnosis and/or reason for consultation or medical treatment. _____
4. Describe nature and cause of injury or sickness (or death):

_____
_____
_____
_____
_____
_____
_____
_____
_____

5. Have you ever suffered this or a similar condition or was this recurrence of a previous illness or injury? Yes ☐ No ☐

   If yes, please provide details, including dates: _____

6. Names and addresses of usual attending Physician(s): _____

7. Names and addresses of witnesses to the Accident, if any: _____

8. If Accident was reported to the Police, state name and address of the Police Station where the report was lodged. A copy of the Police report should be attached to this form. _____

C. CLAIM QUANTUM

Date	Nature of expenses incurred	Billed By	Amount & currency
		Total:	

If space is insufficient, please attach a separate sheet

D. SUPPORTING DOCUMENTS

TO FACILITATE CONSIDERATION OF YOUR CLAIM, PLEASE ENSURE YOU SUBMIT ALL THE NECESSARY DOCUMENTS TOGETHER WITH THIS FORM AS SOON AS AVAILABLE:

1. Original detailed medical bills/receipts;
2. Original medical report and/or certification from the attending Physician on the diagnosis;
3. Police report, accident report and/or newspaper report (if any)
4. For death claim: certified true copy of death certificate, coroner's report and/or post-mortem report (if available), claimants' identification documents (such as certified true copy of Grant of Letters of Administration or Grant of Probate). Legal documents where and when required by law, must be submitted at the claimants' expense.

Additional documents or information may be necessary for certain claims, in which case we will contact you as soon as possible.

PERSONAL DATA PROTECTION

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

(a) Federal Insurance Company, may/is permitted to collect, use, disclose and/or process our/my personal data/personal information set out in this form and any other personal information provided by me or possessed by Federal Insurance Company (collectively the "Personal Information") and disclose and transfer such Personal Information to its lawyers/law firms, 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 investigations relating to the claims;
(ii) investigating the accident and/or my claims;
(iii) carrying out and/or dealing with my instructions or responding to any enquiries by us/me;
(iv) administering my claims (including the mailing of correspondence, statements, invoices, reports or notices to me, which could involve disclosure of certain personal data about us/me to bring about delivery of the same as well as on the external cover of envelopes/mail packages); and/or
(v) complying with applicable law in administering, processing, handling and/or dealing with us/my claims.

(collectively the "**Purposes**")

(b) Federal Insurance Company's lawyers/law firms, may/are permitted to collect, use, disclose and/or process my Personal Information for one or more of the above Purposes; and

(c) our/my Personal Information may/can be disclosed by Federal Insurance Company for one or more of the above Purposes to:
(i) its third party service providers, related bodies corporate, contractors or agents (including their lawyers/law firms), which may be sited outside of Singapore;
(ii) any third party in connection with claims made by or against or otherwise involving us/me in respect of any products or services provided by Federal Insurance Company;

DECLARATION

I hereby declare that to the best of my knowledge and belief, the statements and answers in this form are true and correct in every respect. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

I also hereby authorise any hospital, physician, or other person who had attended to or examined me or my ward/child, to disclose when requested to do so by **FEDERAL INSURANCE COMPANY** or its authorised representative, any and all information with respect to any illness, or injury, medical history, consultations, prescriptions or treatment, copies of all hospital or medical records. A photocopy of this authorisation shall be considered as effective and valid as the original.

PAYMENT OF CLAIM

Subject to Policy terms and conditions, I/we hereby authorise and request Federal Insurance Company to pay the benefit due in respect of this claim to: _____.

Note: Payment is made in the form of Singapore Dollars cheque, regardless of the Insured Person/Claimant's Home Country or Country of Residence/Secondment or the nationality or location of the Policyholder.

Name & Signature of
Insured Person and/or Claimant _____ Date _____

Name, Signature & Designation of
Policyholder's Rep.
(with company stamp) _____ Date _____

MEDICAL CERTIFICATION OF TREATMENT

This certificate is to be completed in full by a duly qualified and registered medical practitioner at the expense of claimant.
Questions 19 and 20 are relevant only if claim is made for Permanent Disablement and Temporary Total/Partial Disablement Benefits covered under the Policy.
Please give a definite answer to each question. Dashes are not sufficient.

1. Name of Patient:	2. Final diagnosis of illness or extent of injury. What are the complaints or physical findings?
3. What was the cause(s) of illness / injury?	
4. Is condition due to pregnancy, infertility or childbirth? Yes ☐ No ☐	5. Is condition a congenital anomaly or a physical defect present at birth? Yes ☐ No ☐
6. Is condition a mental or nervous disorder? Yes ☐ No ☐	7. Was condition due to self-inflicted injury or sexually transmitted disease? Yes ☐ No ☐
8. When did the patient first consult you for this condition? Date:	9. Did patient have any symptoms prior to consulting you? Yes ☐ No ☐ If yes, please state date symptoms first started:
10. Please specify the approximate date of discovery of the illness or injury. Date:	11. If this condition existed before symptoms became apparent to the patient, please state when in your view this condition began to develop. Date:
12. Has patient ever had same or similar condition? Yes ☐ No ☐ If yes, please state when and describe. Date(s) Description	13. Has patient ever consulted any other doctors for the same or similar condition? Yes ☐ No ☐ If yes, please state: Date(s) Names and Addresses of other doctors
14. Was the patient referred by any doctor to see you? Yes ☐ No ☐	15. Please state the name and address of the referring doctor.
16. Please describe the surgical procedures or treatment rendered. Date the surgical procedures or treatment was rendered:	17. Was surgery / treatment done for cosmetic reasons? Yes ☐ No ☐ 18. Is this an elective surgery / treatment? Yes ☐ No ☐
19. How long has the patient been totally or partially disabled from engaging in or attending to usual business as the result solely of the injury? How much longer do you consider such disablement will continue?	Totally from _____ To _____ Partially from _____ To _____ Totally from _____ To _____ Partially from _____ To _____
20. Is patient fit for work? If yes, please state date:	Yes ☐ Date No ☐

I certify that I have satisfied myself by personal examination of the Patient and the foregoing statements are correct to the best of my knowledge and belief. Should the insurance company requires further medical information in connection with the above, I would release the said information upon the sanction of the Patient.

Signature of Physician / Surgeon: _____ Date: _____

Name and Title (with Official Stamp): _____ Name and Address of clinic / hospital: _____