INDIA INTERNATIONAL INSURANCE PTE LTD

WORK INJURY COMPENSATION CLAIM FORM

PARTICULARS OF ACCIDENT TO BE FURNISHED BY THE EMPLOYER

Answering these questions does not imply that the injured person is making, or will make a claim and this form is sent without prejudice to the terms and conditions of Policy.

NOTE : 1. All written communications should be forwarded to the insurer.
2. The acceptance of this Form is not in itself an admission of liability on the part of the Company.

Name of Insured	
Business	Total No. of Employees
Address	
Telephone No. Fax No. Policy No.	
Do you have any other Work Injury Compensation Policy? No/ Yes	
PARTICULARS OF THE INJURED PERSON	
Name	I/C No./Work Permit No. Age
Nationality	Occupation
Address	No. of working days per week
Was the injured person engaged in this occupation when the accident occurred?	
When did the injured person enter your service? How many workers were employed by you at the time of the accident?	
Is the injured person in your direct employ? If no, please provide details, name and address of Contractor	
Name of Hospital taken to	
In or out-patient	
State whether still in hospital or when discharged	
Has the injured person been medically examined? If yes, please send report. If no, was free medical examination offered?	
Stated whether returned to work, and if yes, when	
Are you satisfied the injured person has met with a bona fide accident of employment?	
Is the injured person able to do partial work?	
What is the probable period of disablement (approximate)?	
State whether the injured person has sustained any previous injury under your employment. If so, please give full particulars	
PARTICULARS OF THE ACCIDENT & INJURY Date Time Place	
Upon what date did you receive notice of accident and from whom? If yes, in writing, please attach to this form	
On what date did the injured person actually cease work?	
If accident was due to machinery or gearing, please state: (a) whether it was fenced or guarded (b) Was it being cleaned whilst in motion	
State nature of injury	
State regions injured	
State right or left side	

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Was the injured person under the influence of drink or drugs at the time of accident?	
Was he guilty of any misconduct or disobedience to orders or rules? If yes, please give full particulars	
State through whose neglect the accident occurred, if any	
If the injury was caused by any person or persons not in your employ, please advise full names & addresses of those concerned	
State the names and addresses of any person who witnessed the accident	
Has the accident been reported to Ministry of Manpower? If yes, when did you report If no, please provide reason for non-reporting	

Please provide details on the circumstances of the accident :

ADDITIONAL PARTICULARS FOR FATAL CASES ONLY

Has the deceased any dependants? State the names, addresses and relationship	

In connection with FATAL CASES, please forward a copy of the Police Report together with a copy of the Death Certificate and/or Post-modem report

EARNINGS OF THE INJURED PERSON

The object of this section is to ascertain the exact Monthly earnings of the injured person. It is essential that it should be carefully and correctly filled in. If the injured person has been absent from work at any time during the period of his employment, please state the period and the cause.

Gross Monthly Earnings for 12 months preceding Date of Accident

Month	Grossly Monthly Earnings (Excluding Bonus)	Annual Wage Supplement/Bonus Paid during last 12 months
Total		
Average		

I/We hereby declare that the particulars provided by me/us are true to the best of my/our knowledge and belief.

Date _____

Employer's signature _____
(Name of Employer and Company's stamp)

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