MSIG Insurance (Singapore) Pte. Ltd.
4 Shenton Way #21-01 SGX Centre 2 Singapore 068807
Claim Hotline: (65) 6827 7660 (24 hours) Fax: (65) 6225 6371
Co. Reg. No. 200412212G

Personal Accident Claim Form

Policy Number	

Please note that this form is issued without admission of liability. Please state all relevant information requested as complete and as accurate as possible.

Particulars of Insured (Company / Individual)

Name of Insured (As in NRIC/Passport)+			GST Registration Number+
Business / Home Address*			Effective Date of Registration+ (dd/mm/yyyy)
Contact Person+			Business / Occupation
Contact Number (H)	(O)	(HP)	Email

Particulars of Insured Person / Claimant

Name of Insured Person / Claimant (As in NRIC/Passport)			
Gender ❑ Male ❑ Female	NRIC/Passport/BC Number		Occupation
Date of Employment (dd/mm/yyyy)	Date of Birth (dd/mm/yyyy)		Relationship to Insured
Contact Number (H)	(O)	(HP)	Email

\+ If applicable * Delete if not applicable

Details of Claim

ACCIDENT

Date (dd/mm/yyyy)	Time ❑ am ❑ pm	Place

Is this a job-related accident? ❑ Yes ❑ No

State fully what happened

INJURY

Nature and Extent of injury sustained

Has the insured person previously suffered from an injury to the same part? ❑ Yes ❑ No
If Yes, please give details:

What is the probable period of disablement?

Are there any more medical bills to be submitted? ❑ Yes ❑ No

DEATH (if applicable)

In what capacity are you claiming the insurance? Please state your relationship with the Deceased

SICKNESS (if applicable)

Nature of Sickness / Symptom

Date First Began (dd/mm/yyyy)	Date First Treated (dd/mm/yyyy)

Has the sickness been treated previously? ❑ Yes ❑ No
If Yes, please state Name and Address of the Physician:

Date of previous treatment:

Is the sickness due to pregnancy, abortion, miscarriage, sterilization or infertility? ❑ Yes ❑ No
If Yes, please specify condition:

Date of commencement:

OTHER INSURANCE OR COMPENSATION

Is the insured person/claimant presently also insured for medical insurance under another Insurance Company? ❑ Yes ❑ No
If Yes, please state Name of Insurance Company and Policy Number:

Is the insured person/claimant claiming from another Insurance Company/other sources? ❑ Yes ❑ No
If Yes, please provide a copy of their settlement details.

Supporting Documents

1. Original medical bills / receipts
2. Medical Certificates
3. Medical Report / Discharge Summary
4. Police Report, if applicable
5. Death Certificate and Letters of Administration / Probate, if applicable
6. Coroner's findings / Post Mortem Report / Toxicological Report

Medical Authorization (This portion must be completed by the Insured Person / Claimant)

I hereby authorize any hospital physician or other person who has attended or examined me to furnish to the Insurer or its representative any and all information on my illness, injury, medical history, consultations, prescriptions or treatment, with copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Insured Person / Claimant

Name of Insured Person / Claimant

Declaration

I/We declare that the information given is true and correct to the best of my/our knowledge and belief. I/We understand that any false or fraudulent statements or any attempt to suppress or conceal any material facts shall render the policy void and I/we shall forfeit my/our rights to claim under the policy.

Please make the cheque payable to _____

Signature of Insured

Company's Stamp (if applicable)

Name

Date

MEDICAL REPORT

The Claimant must obtain at his/her own expense the medical report from his/her Medical Attendant.

TO BE COMPLETED BY ATTENDING PHYSICIAN / SURGEON

Name of Patient	NRIC Number

What is the cause of the injury / sickness?

Final Diagnosis

Nature and Extent of injury / sickness

Is he under the influence of intoxicants at the time of accident? ❑ Yes ❑ No

Is injury likely to cause loss of use of the injured part? ❑ Yes ❑ No

Is such loss likely to be permanent? ❑ Yes ❑ No
If Yes, to what extent (in percentage)?

If the condition / disability suffered due to sickness, please elaborate and state the extent to which his recovery has been or may be impeded

Date when symptom first started	Approximate date of discovery of the injury/sickness	When did patient first consult you for this condition?

Details of presented symptoms, Nature and Date of Treatment rendered

Doctors previously consulted by the patient for the above condition:

Name of Physician	Date	Name of Clinic / Hospital	Address

Is the patient still under your care for this condition? ❑ Yes ❑ No

Signature of Physician / Surgeon

Date

Name / Designation

Name and Address of Clinic / Hospital