MSIG Insurance (Singapore) Pte. Ltd.
4 Shenton Way #21-01 SGX Centre 2 Singapore 068807
Claim Hotline: (65) 6827 7660 (24 hours)
Claim Email: claims@sg.msig-asia.com
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 completely and as accurately 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?If Yes No
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?If Yes, please state Name of Insurance Company and Policy Number: ☐ Yes ☐ No

Is the Insured Person/Claimant claiming from another Insurance Company/other sources?If Yes, please provide a copy of their settlement details. ☐ Yes ☐ No

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

Mode of Payment (if applicable)

My preferred way to receive payment is:

☐ PayNow

Name of Account Holder	NRIC / FIN / UEN Number

☐ Credit to my Bank Account

Name of Account Holder (as in Bank Account)			NRIC / FIN /UEN Number
Bank Name	**Bank Code**	**Branch Code**	**Bank Account Number (Please key in numbers only and omit any dashes '-')**

☐ By Cheque

Name of Payee

Declaration

Please note that you are submitting this claim to MSIG Insurance (Singapore) Pte. Ltd. Please see our full Terms of Use and Privacy & Cookies Policy on our website www.msig.com.sg.

By submitting this claim to us, you are deemed to have agreed to us collecting, using, disclosing and processing your personal data for the purpose of assessing your claim. We may also share your personal data with other Insurers and the General Insurance Association of Singapore (as well as their Third Party service providers) as part of the industry's efforts for proper underwriting and proper administration of claims. This may include sharing the personal data for investigating fraud, exaggerated claims, and other criminal or improper acts.

☐ 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 the Insurer may refuse to pay the claim.

Signature of Insured

Company's Stamp (If applicable)

Name and Designation

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? If Yes, to what extent (in percentage?)	Yes	No	
If the condition / disability suffered is 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 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

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Name / Designation

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Signature of Physician / Surgeon

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Name and Address of Clinic / Hospital

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Date