MSIG Insurance (Singapore) Pte. Ltd. (Co. Reg. No. 200412212G)
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Claim Enquiry: (65) 6827 7660 / claims@sg.msig-asia.com
Claim Notification: claimsnotification@sg.msig-asia.com
A Member of MS&AD INSURANCE GROUP

Work Injury Compensation 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

Name of Insured	GST Registration Number+
Address	Effective Date of Registration+ (dd/mm/yyyy)
Contact Person	Business
Contact Number (H) (O) (HP)	Email

+ If applicable

Particulars of Insured Person / Claimant

Name (As in NRIC / Passport)			NRIC / Passport / WP / FIN Number
Local Residential Address			Occupation
Gender ☐ Male ☐ Female	Date of Birth (dd/mm/yyyy)	Nationality	Date of Employment (dd/mm/yyyy)
Contact Number (H) (O) (HP)			Email

What were the duties of the Injured Person?	
Was the Injured Person engaged in these duties when the accident occurred?	☐ Yes ☐ No
Is the Injured Person in your direct employment? If No, please provide: Name and Address of Employer: Name of Insurance Company and Policy Schedule:	☐ Yes ☐ No
Where was the Injured Person medically examined / treated? Name of Clinic / Hospital taken to:	
State whether still in hospital, or date discharged:	☐ Inpatient ☐ Outpatient
State date the Injured Person returned to work:	
What is the probable period of incapacity?	
Are you satisfied the Injured Person has met with a bona fide accident arising out of his employment?	☐ Yes ☐ No
Has the Injured Person received compensation for previous disability? If Yes, please give full details:	☐ Yes ☐ No

Details of Accident

Date of Accident (dd/mm/yyyy)	Time of Accident ☐ am ☐ pm	Place of Accident

When did you receive notice of accident and from whom? (If in writing, please attach to this form)
When did the Injured Person actually cease work?
Explain in details exactly how the accident happened, specify the tasks and operations involved
State nature of injury in detail

Body part injured
Is the body part injured on the left or right side?
Was the Injured Person performing work on a Contract / Project undertaken by you? ☐ Yes ☐ No If Yes, please provide: Name of Main Contractor: Address: Name of Insurance Company and Policy Schedule:
Was anyone supervising the work the Injured Person was performing? ☐ Yes ☐ No If Yes, please state Name of Supervisor and Employer:
Was the Injured Person under the influence of alcohol or drugs at the time of the accident? ☐ Yes ☐ No
Was he guilty of any misconduct or disobedience to orders or rules? ☐ Yes ☐ No If Yes, please elaborate:
Through whose neglect the accident occurred? Please state reason:
State the names of any persons who witnessed the accident:
Has the accident been reported to Ministry of Manpower? ☐ Yes ☐ No
Has the accident been reported to Police? ☐ Yes ☐ No (If Yes, please furnish a copy of Police Report)

Additional Details For Fatal Cases Only

Does the Deceased have any Dependants? ☐ Yes ☐ No
If Yes, please state names, addresses, gender, relationship, ages and occupations (if any) on a separate piece of paper.
Date of Inquest (if any):
Please furnish a copy of i) Post Mortem Report ii) Death Certificate iii) Police Report

Declaration of Earnings

Statement of earnings of the Injured Person earned IN THE PRESENT EMPLOYMENT for the twelve months immediately prior to the date of this Accident, or earnings earned during such shorter period as he may have been in the Employer's service.

"Earnings" include wages, allowances, overtime payments, bonuses or annual wage supplement but does not include travelling allowances, employer's CPF contributions or pensions or monies paid to cover any special expenses incurred by the employee by nature of his employment.

Note: The objective of this form 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 cause.

Year	Month	Gross Monthly Earnings (S$)	Bonus, Overtime, Allowances (S$)
	TOTAL	0	0
	Average	0	0

Indicate the number of working days per week: 5 days / 5½ days / 6 days	Others, please state:

OTHER INSURANCE OR COMPENSATION

Do you have any other Work Injury Compensation Policy? ☐ Yes ☐ No
If Yes, please state Name of Insurance Company and Policy Number:

Supporting Documents

1. Copy of iReport to Ministry of Manpower
2. Copy of Work Permit/ Employment Pass if the worker is a foreign national
3. Original Medical Bills and original Medical Certificates
4. Copy of Discharge Summary, if applicable
5. Copy of wage vouchers for the period of 12 months preceding the accident

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 '-')**

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.

☐ We declare that the information given is true and correct to the best of our knowledge and belief. 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

Name and Designation

Date