Grab

Prolonged Medical Leave Insurance/ Rental Recovery Claim Form

SG020

CHUBB®

Important Notes

This claim form is to facilitate your claim in the event of you or a member of your family is Insured under a Personal Accident policy.

You can help to avoid unnecessary delay in processing your claim by ensuring that:

1. Claim Form is fully completed and signed by the Insured and/or Claimant. Please attach a detailed copy of the Pre-Medical/Final Hospitalisation/Post-Medical Report/ In-Patient Discharge Summary to the Claim Form.

2. Section G is completed by the Claimant's Attending Physician. Please note that you or the Claimant is responsible for any expenses incurred in obtaining medical evidence in support of the claim.

The issue and acceptance of this form and its accompanying documents (if any) does NOT constitute an admission by Chubb Insurance Singapore Limited (Chubb) that any part or the whole of the Claimant's claim is accepted. It also does not constitute a waiver of Chubb's rights in accordance with the terms and conditions of the Policy.

Section A: Particulars of Insured Person

Name of Insured Person (as shown in NRIC/Passport):

Address:

Postal Code:

Policy No(s):

NRIC/Passport No.: Date of Birth: DD / MM / YYYY

Nationality: Age:

Tel No. (Mobile): Gender: Male Female

Tel No. (Office): Tel No. (Residence):

Occupation:

Email:

If you are a Driver, please indicate the following:

Driver's Tier:

Do you have an active rental agreement with GrabRental or GrabRental's Affiliated Partner on the occurrence of the event?

Section B: Payment Details

Please provide details for payment of your claim in the event that the claim is deemed payable by Chubb.

I hereby authorise and request Chubb to pay benefit due in respect of this claim as follows (Name as per Identification Card and/or Bank Account):

☐ **Electronic Funds Transfer** - For payments in SGD and to bank accounts in Singapore (Recommended)

Payee Name (as per bank account name):

Name of Bank:

Branch Code No.: Account No.:

Note: For a more seamless experience, we recommend selecting the Electronic Funds Transfer (EFT) option so you can receive the remittance within 3-5 days upon approval of claim.

☐ **Cheque Payment**

Payee Name (as per bank account name):

Note: If no name is provided, settlement will be effected to the payee as provided for under the terms of the policy.

Important Notice:
Chubb shall (i) be discharged from all liability under this claim and (ii) not be liable for any and all losses incurred by you, as a result of you providing Chubb with an incorrect bank account number under this section for the payment of this claim.

Section C: Details of Sickness/Accident

Date of Sickness/Accident DD / MM / YYYY Time of Sickness/Accident (24-Hour) H H : M M

Place of Sickness/Accident

Description of Sickness/Accident (Please enclose a copy of the Police Report if the accident is due to a road traffic accident).

Section D: Details of Medical Leave due to Accident and Sickness

- Only applicable for Diamond, Sapphire and Ruby Drivers.
- Please remember to affix the company stamp to claim for Temporary Total Disablement.

Medical Certificate From: DD / MM / YYYY To: DD / MM / YYYY Date returned/expected to return to work DD / MM / YYYY

Will there be more medical bills to be submitted at a later date? ☐ Yes ☐ No

Section E: Details of Hospitalisation due to Accident and Sickness

- Only applicable for Diamond, Sapphire and Ruby Drivers.
- Please attach In-Patient Discharge Summary/Medical Report.

Name of Hospital: _____ Period of Hospitalisation From: DD / MM / YYYY To: DD / MM / YYYY

Section F: Declaration

Did you remember to enclose the following? (Where applicable)

Document	Yes	N/A
Medical Certificate	☐	☐
Doctor's memo on diagnosis (Outpatient)	☐	☐
In-Patient Discharge Summary/Medical Report (Inpatient)	☐	☐
Rental agreement with GrabRental or GrabRental's Affiliated Partner	☐	☐

By signing this form, I/We agree that Chubb will use the information supplied here and during the formation and performance of my policy, for policy administration, customer services, claims handling and fraud analysis and prevention, and that Chubb may disclose such information to its service providers, agents, authorities and other parties for these purposes.

I/We hereby authorise any hospital, physician, and any other person or entity who has attended to or examined me, to furnish to Chubb or its authorized representatives, any and all information with respect to any illness or injury or loss, medical history, consultation, prescriptions or treatment, copies of all hospital, medical or other records, investigation status and results, and such personal information as Chubb in its absolute discretion considers relevant for its assessment of my claim. A photostatic copy of this authorisation shall be considered as effective and valid as the original.

I/We do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I/We agree that if I/We have made or in any further declaration or representation shall make any false or fraudulent statements or suppress, conceal or falsely state any fact whatsoever the Policy shall be void and all rights to recover thereunder in respect of past, present or future claims shall be forfeited.

Signature of Claimant

Signature of Insured Person
(if different from Claimant)

Date

Note:

Kindly submit the completed claim form via email to A&HClaims.SG@Chubb.com. Please ensure that the relevant supporting documents are submitted as well.

Contact Us

Please visit our website at www.chubb.com/sg or contact us at +65 6398 8000.

Section G: Attending Physician's Statement (To be completed by attending physician)

Note: You are required to complete this section if you are making a claim **without** a Doctor's Memo, Medical Report or In-Patient Discharge Summary.

Name of Patient

NRIC/Passport No. Date of Birth DD / MM / YYYY Gender Male Female

Date on which you first saw the Patient DD / MM / YYYY

Is it due to Sickness or Injury? Sickness Injury Date of sickness/injury DD / MM / YYYY

Was the Patient referred to you by another physician? Yes No

If **Yes**, please provide the Name and Address of the referral physician.

Name of Physician

Address

Postal Code

What symptoms did the Patient complain of?

According to the Patient, how long has he/she been experiencing these symptoms?

In your opinion, how long did the symptoms last?

Has the Patient seen any other physician or receive treatment on account of these symptoms previously? Yes No

If **Yes**, please provide details.

What was your final diagnosis?

Did the injury result in any fracture of bones? Yes No

If **Yes**, please state which part(s) of the body.

Has the Patient previously suffered from an injury on the same part? Yes No

Did the injury or sickness require the following?

1. Hospitalisation ☐ Yes ☐ No
   (Please state period of hospitalisation: From DD / MM / YYYY to DD / MM / YYYY)
2. X-rays ☐ Yes ☐ No
3. Special diagnostic procedure ☐ Yes ☐ No
4. Surgery ☐ Yes ☐ No
   (Please specify the type of surgery: _____)

Is the Patient still under your care for this condition? ☐ Yes ☐ No

Bearing in mind the Patient's occupation as stated overleaf, do you feel that the injuries or sickness would have prevented him/her from working? ☐ Yes ☐ No

Please state the reason why.

How long was the patient totally disabled (unable to work)?

Will the Patient continue to be totally disabled (unable to work)? ☐ Yes ☐ No

How long was the patient partially disabled?

Will the Patient be partially disabled? ☐ Yes ☐ No

Give details of any circumstances, such as the influence of alcohol, drug or any other intoxication substance, physical defects or medical history which may have contributed to the accident or sickness and/or lengthen the period of disability.

I hereby certify that I have personally examined and treated the patient for the above injury / sickness and that the facts as given above present my opinion of his/her condition.

Name of Physician

Qualification

Official Address:

Postal Code:

Tel /Fax No.:

Signature with Official Stamp

Date (DD/MM/YYYY)

Please click to submit your claim form Submit

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