

# Liability

## Claim Form



\*SG011\*

CHUBB

### **Important Information**

---

The information requested and documents mentioned in this form are a general guide. Further documents or information may be required depending on the circumstances of your claim. Note that failure to provide supporting documentation may result in delays in the processing of your claim.

Your Policy may not provide cover under every section shown in this Claim Form.

The issuance and acceptance of this form does NOT constitute an admission of liability by Chubb Insurance Singapore Limited (Chubb) or waiver of its rights.

## Section A: Particulars of Policyholder / Insured Person

---

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

---

Address of Policyholder / Insured Person

---

Postal Code \_\_\_\_\_

Policy No. \_\_\_\_\_

Period of Insurance From DD / MM / YYYY To DD / MM / YYYY

Tel No. (Mobile) \_\_\_\_\_ NRIC / Passport No. \_\_\_\_\_

Tel No. (Residence) \_\_\_\_\_ Age \_\_\_\_\_

Tel No. (Office) \_\_\_\_\_ Nationality \_\_\_\_\_

Date of Birth DD / MM / YYYY Gender  Male  Female

Date of Employment DD / MM / YYYY Occupation \_\_\_\_\_

Email \_\_\_\_\_

Name of Intermediary (if any) \_\_\_\_\_

Name of Insured Person (if different from Policyholder)

---

Address of Insured Person

---

Postal Code \_\_\_\_\_

Tel No. (Mobile) \_\_\_\_\_ NRIC / Passport No. \_\_\_\_\_

Tel No. (Residence) \_\_\_\_\_ Age \_\_\_\_\_

Tel No. (Office) \_\_\_\_\_ Nationality \_\_\_\_\_

Date of Birth DD / MM / YYYY Gender  Male  Female

Date of Employment DD / MM / YYYY Relationship to Policyholder \_\_\_\_\_

Occupation \_\_\_\_\_

Email \_\_\_\_\_

**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:

**Cheque Payment**

Payee Name (as per bank account name) \_\_\_\_\_

**Electronic Funds Transfer** (for payments in SGD and to bank accounts in Singapore)

Payee Name (as per bank account name) \_\_\_\_\_

Name of Bank \_\_\_\_\_

Branch Code No. \_\_\_\_\_ Account No. \_\_\_\_\_

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

**Section C: Details of Loss / Occurrence**

---

Country of Loss / Occurrence  Singapore  Malaysia  Others \_\_\_\_\_

Place of Loss / Occurrence \_\_\_\_\_

Date of Loss / Occurrence DD / MM / YYYY Time of Loss / Occurrence (24-Hour) HH : MM

Describe how the incident / loss took place (Please use supplementary sheet if necessary)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When and by whom was the loss discovered \_\_\_\_\_

Relationship of Third Party Claimant to the Insured \_\_\_\_\_

Were there witnesses to the incident?  Yes  No

If **Yes**, please provide details below:

	Witness 1	Witness 2
Name		
Address		
NRIC		
Contact Number		

**Section D: Police Report**

---

**Please note:**

- 1) The Police must be informed immediately if the property has been lost or maliciously damaged.
- 2) A copy of the Police Report / Statement must be attached.

Were particulars of loss taken by or reported to the Police?  Yes  No

If **Yes**, please furnish with details below:

Name of Police Station \_\_\_\_\_

Date of Report DD / MM / YYYY Time of Report (24-Hour) HH : MM

If **No**, please state reason(s) that the Loss was not reported to the Police:

---

---

---

---

**Section E: In Product Cases Only**

Please give details of the product alleged to have caused injury / damage; your opinion on cause; details of any defects; identity of distributor / retailer and other comments. (Please use supplementary sheet if necessary)

---

---

---

---

What duty did you owe to the Third Party Claimant, Injured person or Owner of damaged property?

---

---

How could you have prevented the incident?

---

---

**Section F: Details Of Person(s) Injured**

(Please use supplementary sheet if necessary)

Name, Address and Contact No. of Person Injured	Age	Nature of Injuries / Remarks	Name of Hospital The Person Injured was Conveyed To	Occupation / Nature of Work

Is he / she in your employment?

Yes  No

Was he / she under the influence of intoxicating liquor or drugs at the time of accident?

Yes  No

If **Yes**, please give details:

---

---

Was he / she guilty of misconduct, or of disobedience to instructions or rules?

Yes  No

If **Yes**, please state the nature:

---

---

In your opinion, was he / she responsible for the incident?

Yes  No

If **Yes**, please state the reason(s):

---

---

### Section G: Details of Property Damaged

(Please use supplementary sheet if necessary)

Name, Address and Contact No. of Owner of Property Damaged	Name and Extent of Property Damaged	Approximate Value of Property Damaged	Estimated Cost of Repairs to The Property Damaged

Has any claim been made upon you?

Yes  No

If **Yes**, please state details and attach all communications received from third party claimant(s):

---

---

Have you admitted responsibility in any way?

Yes  No

If **Yes**, please state the reason(s) for doing so:

---

---

### Section H: Any Other Insurance

Are there any other policies of insurance in force covering you or the subject matter in respect of this event?

Yes  No

If **Yes**, please specify below:

Name and Address of Insurance Company(s)	Policy No(s).

Are you claiming under any of the policies listed above?

Yes  No

**Section I: Claims History**

Have you or any Insured person previously made claim(s) for loss / damage or caused damage / injury to third parties?  Yes  No  
 If **Yes**, please furnish with details below:

(Please use supplementary sheet if necessary)

Name of Insurer	Claim No.	Date of Loss	Nature of Loss	Amount Paid

**Section J: Declaration**

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

Document	Yes	NA
Incident or Investigation Report	<input type="checkbox"/>	<input type="checkbox"/>
Police Report	<input type="checkbox"/>	<input type="checkbox"/>
CCTV footage (i.e. Evidence of circumstances leading to the incident)	<input type="checkbox"/>	<input type="checkbox"/>
Photographs showing the damage to the items and / or bodily injuries	<input type="checkbox"/>	<input type="checkbox"/>
Copy of Assessment Report / estimates from Repairer indicating the cause and extent of damage incurred (if involved damaged item(s))	<input type="checkbox"/>	<input type="checkbox"/>
Copy of Medical Report of third party/parties (if involved bodily injuries)	<input type="checkbox"/>	<input type="checkbox"/>
Settlement / Contractual Agreement from third party / parties concerned (if involved bodily injuries)	<input type="checkbox"/>	<input type="checkbox"/>
Letter of Demand from the third party / parties concerned (e.g. Writ of Summons)	<input type="checkbox"/>	<input type="checkbox"/>

By signing this form, I / We agree that Chubb will use the information supplied here and during the formation and performance of the 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 authorise any person or entity to provide to Chubb or its authorised representatives, any and all information with respect to any loss and claims, police records, investigation status and results, and such personal information as Chubb in its absolute discretion considers relevant for its assessment of this 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.

\_\_\_\_\_  
 Name and Designation of Policyholder

\_\_\_\_\_  
 Signature with Company Stamp (if applicable)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Name of Insured Person (if different from Policyholder)

\_\_\_\_\_  
 Signature of Insured Person

\_\_\_\_\_  
 Date

**Note:**

Kindly submit the completed claim form in person, through your Broker, or by mail to Chubb Insurance Singapore Limited at 138 Market Street #11-01 CapitaGreen Singapore 048946. Please ensure that the relevant original copies of supporting documents are submitted as well.

**Contact Us**

Chubb Insurance Singapore Limited  
 Co Regn. No.: 199702449H  
 138 Market Street  
 #11-01 CapitaGreen  
 Singapore 048946  
 O +65 6398 8000  
 F +65 6298 1055  
 www.chubb.com/sg

**Chubb. Insured.<sup>SM</sup>**