CHUBB®

Work Injury Compensation
Claim Form

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.

Instructions:
Please download/save this claim form to enter your claim details. Kindly submit the completed claim form via one of the following options:

- By email: WICAclaims.SG@chubb.com (**Recommended**); or
- Contact your broker/agent.

When submitting your claim, please include copies of the relevant supporting documents. For more information, contact us

- O +65 6398 8000; or
- Visit our website at www.chubb.com/sg

Important Note: Please ensure that you retain the original medical receipts/hospital bills/medical certificates for 3 years. We reserve the rights to request for sight of the original documents on a need-be basis.

Section A: Particulars of Insured Company and Injured Worker

Name of Insured Company

____

Address of Insured Company

____

____

Tel No. (Office) ______________ Name of Agent/Broker ______________

Fax No. (Office) ______________ Total No. of Employees ______________

Industry of Business ______________ Email Address ______________

Policy No. ______________

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

Name of Injured Worker ______________

Address of Injured Worker

____

____

NRIC/Passport No. ______________ Nationality ______________

Date of Birth DD / MM / YYYY Age ______________

Tel No. (Mobile) ______________ Gender ☐ Male ☐ Female

Tel No. (Residence) ______________ Occupation ______________

Date of Employment DD / MM / YYYY No. of days worked per week ______________

Direct Employment ☐ Yes ☐ No ☐ Others (please specify) ______________

Type of Employment ☐ Permanent ☐ Contract ☐ Others (please specify) ______________

Was the Injured Worker free from any physical defect or infirmity at the time of accident? ☐ Yes ☐ No

If No, please furnish with details.

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____

Would such physical defect or infirmity have contributed towards this accident? ☐ Yes ☐ No

If Yes, please furnish with details.

____

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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:

☐ **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 Number: ____________________ Account Number: ____________________

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** (Not recommended)

Payee Name (As per bank account name): ____________________

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 Accident

Date of the Accident DD / MM / YYYY Time of the Accident (24-hr) H H : M M

Country of Accident ____________________ Place of Accident ____________________

Describe in detail how the Accident occurred (Please use supplementary sheet if necessary and also state the type of machinery involved, if any)

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When did you receive news of the Accident ____________________

When and by whom was the Accident discovered ____________________

Relationship of person to the Injured Worker ____________________

Were there witnesses to the incident? ☐ Yes ☐ No

If Yes, please provide details below:

	Witness 1	Witness 2
Name		
Address		
NRIC		
Contact Number		

Describe the nature of the work or contract going on at the material time.

____

Are you satisfied that the Injured Worker has met with a bonafide accident of employment? ☐ Yes ☐ No

If No, please state reason(s):

____

Did this accident occur as a result of another person's negligence? ☐ Yes ☐ No

If Yes, please provide details of Negligent party:

____

Was the Injured Worker guilty of any misconduct/disobedience to orders/rules? ☐ Yes ☐ No

If Yes, please state the misconduct:

____

Was the Injured Worker under the influence of drink or drugs at the material time? ☐ Yes ☐ No

If Yes, please specify:

____

____

Has the Injured Worker met with any previous accident under your employment? ☐ Yes ☐ No

If Yes, please furnish details:

____

____

Has this accident been reported to the Ministry of Manpower? ☐ Yes ☐ No

If Yes, please attach a copy of I-REPORT.

Please state the date that the Injured Worker returned to work DD / MM / YYYY

Section D: Nature of Injury

Describe in detail the injuries sustained, indicating the Part(s) of body injured and its type of injury (E.g. Fracture, Cut, Bruise, etc).
(Please use supplementary sheet if necessary)

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Has the Injured Worker ever had this or any similar condition or injury? ☐ Yes ☐ No

If Yes, please furnish details:

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Please state all medical condition(s) or previous injury sustained by the worker and also indicate which are the injuries that arose out of Work Injury accidents.
(Please use supplementary sheet if necessary)

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Date of first treatment sought DD / MM / YYYY

Name of Hospital/Clinic ____

Address of Hospital/Clinic ____

Tel/Fax No. ____

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

Period of Medical Leave From DD / MM / YYYY To DD / MM / YYYY

Light Duties From DD / MM / YYYY To DD / MM / YYYY

Section E: Detailed Earnings of The Injured Worker

Please provide detailed gross monthly earnings of the Injured Worker for 12 months (before month of accident):

Month/Year	Gross Monthly Earnings (Exclude Bonuses, Transport Allowance, CPF Employer's Portion)	Annual Wage Supplement/Bonus Paid During Last 12 Months
Total Annual Earnings		
Average Monthly Earnings		

Section F: Declaration

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

Document	Yes	N/A
Copy of iReport submitted to Ministry of Manpower	☐	☐
Medical Bills and Medical Certificates	☐	☐
Copy of Salary Vouchers for the last 12 months (before month of accident)	☐	☐
Copy of Work Permit or Employment Pass (for Foreign employees)	☐	☐
Written notes from Physician on type of injury sustained/Inpatient Discharge Summary or Medical Report	☐	☐
Copy of Death Certificate, Post Mortem Report, Autopsy Report, Police Reports, Letter of Administration (if involved fatalities)	☐	☐
Copy of Contractual Agreement between Insured, Sub-Contractor(s) and/or Main Contractor	☐	☐
Copy of Sub-Contractor's and/or Main Contractor's Work Injury Compensation Insurance Policy	☐	☐

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 hereby authorise any hospital, physician, and any other person or entity who has attended to or examined the injured party, to furnish to Chubb or its authorised 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 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 Authorised Person

Signature with Company Stamp

Date (DD/MM/YYYY)

Name of Injured Worker

Signature of Injured Worker

Date (DD/MM/YYYY)

NRIC/Passport No./Work Permit No. of Injured Worker

Please click on the button to submit your claim form

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