

Allianz Insurance Company of Singapore Pte Ltd

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Company's Registration No. 199000540G



PERSONAL ACCIDENT INSURANCE CLAIM FORM

IMPORTANT NOTICE

The acceptance of this form is not an admission of liability. It should be completed as fully and accurately as possible and returned immediately.

PARTICULARS OF INSURED	
Name of Insured	NRIC/Passport No.
Policy No.	Contact Person/Telephone No.
Occupation/Business	Are you GST registered at the commencement of the Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
Postal Address	

PARTICULARS OF INSURED PERSON	
Name of Insured Person	NRIC/Passport No.
Occupation	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth	E-mail
Mobile No.	Office No.
Home Address	

PARTICULARS OF THE ACCIDENT		
Date of Accident	Time of Accident	Place of Accident
Describe exactly how the accident occurred		
When and by whom was the accident discovered		
Provide names and contact details of all witnesses	(1)	
	(2)	
	(3)	

NATURE OF INJURY

Describe in details the injuries sustained, indicating the part of the body injured and the type of injury (eg. Fracture, cut, bruise, etc.)

Has the same part been injured previously?
If yes, please provide details

Yes No

Name and Address of doctor(s) who treated you and consultation date(s).

Name and Address of your usual doctor.

Details of hospitalisation (please attach discharge summary & hospital bill):

(a) name of hospital

(a) _____

(b) period of hospitalisation

(b) Date Admitted: _____ Date Discharged: _____

Details of Temporary Disability from engaging in or attending to your usual business as a result of the injuries.

(a) light duties

(a) from _____ to _____

(b) medical leave

(b) from _____ to _____

Date returned/expected to return to school/work

ANY OTHER INSURANCES

1. Is this job related injury? (If yes, copy of the reports to the Ministry of Manpower must be attached.) Yes No

2. Are you claiming from any other insurance company or other sources in respect of this injury? If yes, state:

Name of Company

Policy No.

Amount of compensation

Date of Insurance Effected

DECLARATION AND AUTHORISATION

1. I hereby declare that the above statements are true and complete to the best of my knowledge. I give consent to Allianz Insurance Company of Singapore Pte Ltd to seek information from any doctor, hospital or organisation and authorise the provision of such information. A photocopy of this authorisation shall be treated as a valid document.

2. I hereby request and authorize Allianz Insurance Company of Singapore Pte Ltd to pay benefit due in respect of this claim to:

Insured

Insured Person

Insured's Signature: _____ Date: _____ Insured Person's Signature: _____ Date: _____

Insured's Company Stamp: _____

ATTENDING DOCTOR'S STATEMENT

THIS ATTENDING DOCTOR'S STATEMENT IS TO BE COMPLETED AT THE INSURED / INSURED PERSON'S EXPENSE.

1. Patient's Name in Full	
2. The nature and extent of injuries (if to a limb, state whether right or left)	
3. The cause of the accident, so far as known to you	
4. (a) Date of your first attendance upon him in consequence of the injuries sustained	(a)
(b) Are you still in attendance?	(b)
5. (a) Are you his usual Medical Attendant?	(a)
(b) If yes, how long have you known him?	(b)
(c) For what medical condition have you attended to him?	(c)
6. (a) Are the patient's symptoms:- (i) due exclusively to the accident or (ii) traceable to disease, infirmity or any other cause?	(a) (i) (ii)
(b) Is the patient now or was he at the time of the accident suffering from any illness, disease or infirmity? If so, state the nature and to what extent his recovery has been or may be retarded thereby.	(b)
(c) Do you have any reason to believe that he was under the influence of drugs or alcohol at the time of the accident? If yes, please provide details.	(c)
7. Bearing in mind the patient's occupation and the two definitions below, please state:- (a) the period during which the patient has been totally and/or partially disabled from attending to his usual business or occupation	Claimant has been temporarily disabled:- (a) Totally from..... to..... Partially from..... to.....
(b) the probable future duration of (i) total and/or (ii) partial disablement	(b) Totally from..... to..... Partially from..... to.....
8. Has the patient sustained any permanent disablement? If yes, please advise the percentage of permanent disablement.	
9. Is there any other information (professional or otherwise) that you consider should be made known to us? If yes, please advise.	

I hereby certify that the foregoing statements are correct.

Name of physician: _____

Signature: _____ Qualifications: _____

Address: _____ Date: _____

TEMPORARY TOTAL DISABLEMENT - Shall mean a state of incapacity resulting from the Insured Person suffering bodily injury which temporarily totally prevents the Insured Person from engaging in his occupation.

TEMPORARY PARTIAL DISABLEMENT- Shall mean a state of incapacity resulting from the Insured Person suffering bodily injury which temporarily prevents the Insured Person from engaging in a substantial part of his occupation.