



**Tokio Marine Insurance Singapore Ltd.**

Company Reg. No. : 192300014M  
20 McCallum Street  
#09-01 Tokio Marine Centre  
Singapore 069046  
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**Personal Accident Claim Form**

The company does not admit liability by the issuance of this form. The issued form must be completed and returned within seven (7) days of receipt. No claim can be admitted unless Medical Certificate from a duly qualified and Registered Medical Practitioner, on the form annexed be furnished at expense of Insured. Claims Fax No : 6225 9887

Insured

Insured: \_\_\_\_\_

Age: \_\_\_\_\_ NRIC No: \_\_\_\_\_ Policy No: \_\_\_\_\_

Sum Insured: \_\_\_\_\_ Address: \_\_\_\_\_

Tel No/email: \_\_\_\_\_ Occupation : \_\_\_\_\_

Are you self employed? Yes No, If No, state employer's name and address: \_\_\_\_\_

Do you have any other insurance that will cover this loss? Yes No If Yes, please provide details: \_\_\_\_\_

Have you ever made a claim under any PA policy before? Yes No If Yes, state insurer, amount and date: \_\_\_\_\_

Details of Accident

Date: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm Place: \_\_\_\_\_

State particulars of Accident in detail: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of hospital (or clinic) taken to: \_\_\_\_\_ Inpatient Outpatient  
(Please fill in clinic's name if not hospitalized) Admitted on: \_\_\_\_\_ Discharged On: \_\_\_\_\_

State names of witnesses to the accident: \_\_\_\_\_

\_\_\_\_\_

State number of days you expect to be necessarily and entirely confined to House or Hospital, by Doctor's orders as the sole and direct result of the injuries sustained:

To House: \_\_\_\_\_ days

To Hospital: \_\_\_\_\_ days

If still confined, state which:

To House: \_\_\_\_\_ days

To Hospital: \_\_\_\_\_ days

Do you expect in any way to attend to any part of your business or work during the above period. If so please describe as follows:

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Declaration

I hereby declare that I am the person referred to in the foregoing particulars, that I have received the injuries before described by violent, external and visible means. And I do further declare that I have always been uniformly sober and temperate in my habits, and that I was no way under the influence of drugs or intoxicating liquor when the accident occurred, and that I have not abstained from business or work, either totally or partially, longer than absolutely necessary in consequence of the said injuries, and that such injuries are the sole and direct cause of my disablement or loss.

I do hereby warrant the truth of the foregoing statements in every respect, and I agree that if I have made or in any further declaration the Company may require of me in respect of the said accident shall make, any false or fraudulent statement, or any suppression, concealment, or untrue avertainment, the Policy shall be void as against the Company, and my right to compensation absolutely forfeited.

I hereby claim indemnity (compensation) as provided under my Policy as follows:

- 1) Temporary Partial Disablement: \_\_\_\_\_ Weeks @ \_\_\_\_\_ per week = \_\_\_\_\_
- 2) Temporary Total Disablement \_\_\_\_\_ Weeks @ \_\_\_\_\_ per week = \_\_\_\_\_
- 3) Permanent Partial Disablement \_\_\_\_\_
- 4) Permanent Total Disablement \_\_\_\_\_
- 5) Death \_\_\_\_\_

Important Notice: The insured person must, in the event of a claim, advise the company as to any other insurance that they may have covering the same risk.

Declaration: I hereby declare and warrant that all the answers given above to be true. I accept that insurers would be at liberty to deny liability in part or in full if the above written answers are false or inaccurate in any aspect.

Notice for Personal Data Protection Policy

By signing this form:

- i) I/We acknowledge and consent to TMiS collecting, using, processing and disclosing to third party service providers and/or intermediaries, within or outside Singapore, my/our personal data for the purpose of processing and servicing my/our policies/claims;
- ii) I/We declare and confirm that I/we have obtained the consent of the person(s) and/or nominee(s) named herein, where applicable, and that he/she/they has/have authorized me/us to disclose their personal data and to give consent on their behalf for the above collection, use, process and disclosure; and
- iii) I/We acknowledge the detailed Privacy Policy Statement, governing the above, posted at [www.tokiomarine.com.sg](http://www.tokiomarine.com.sg).

Signature : \_\_\_\_\_  
Name : \_\_\_\_\_

Date : \_\_\_\_\_

**MEDICAL REPORT - TO BE COMPLETED BY ATTENDING PHYSICIAN**

Name of Patient: \_\_\_\_\_  
NRIC No.: \_\_\_\_\_ Profession/Occupation: \_\_\_\_\_

Are you the patient's usual medical doctor? Yes No  
Have you attended him for any illness or accident before? Yes No  
If Yes, state for what and when \_\_\_\_\_  
\_\_\_\_\_

How was the present accident caused? \_\_\_\_\_  
After the accident, the first treatment was 1) When? \_\_\_\_\_  
2) Where? \_\_\_\_\_

Was patient in your opinion, perfectly sober at the time of accident? Yes No  
State as fully as possible the nature and extent of injures sustained : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Are injuries on the right or left side? \_\_\_\_\_

In your opinion, are the injuries sustained in line with the accident that patient described? Yes No  
Is the patient now or was he at the time of accident, suffering from or affected by any physical infirmity, disease, or illness, irrespective of the injuries? Yes No  
If Yes, 1) state nature \_\_\_\_\_  
2) extent it impede the recovery of patient \_\_\_\_\_  
Is patient suffering from or does he suffered from any cardiac affection, gout, rheumatism, or fits of any kind? Yes No

Are you aware of anything in the previous medical history of the patient which might have contributed directly or indirectly, to the occurrence of the accident, or which may be likely in any way to retard his recovery from it? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

State whether the patient is confined to bed Yes No  
Is patient prevented from following his usual business or occupation as a direct result of his injuries. Yes No

How long in your opinion will patient be so disabled? \_\_\_\_\_  
State as clearly as possible his present condition \_\_\_\_\_  
\_\_\_\_\_

Signature of Physician/Surgeon : \_\_\_\_\_ Date : \_\_\_\_\_

Name & Designation : \_\_\_\_\_

Name & address of clinic/hospital : \_\_\_\_\_