Tokio Marine Insurance Singapore Ltd.
(Company Reg. No.: 192300014M) (GST Reg. No.: M2-0000023-4)
20 McCallum Street #09-01 Tokio Marine Centre Singapore 069046
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A member of the
Tokio Marine Group

TOKIO MARINE
INSURANCE GROUP

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 email : tmisclaims@tokiomarine.com.sg

Policy Number	

General Information

Type of Claim		
☐ Medical Expenses	☐ Weekly income benefit	☐ Mobility Aid & Prosthesis
☐ Recuperation Benefit	☐ Permanent Disablement	☐ Accidental Death
☐ Extensions (please specify):		

* Note : Please fill in respective column and provide relevant documents

Details of Policyholder	
Name of Policyholder *(as per NRIC/Passport)*	
NRIC Number	Date of Birth *(dd/mm/yyyy)*
Contact Number	Email
Address for Correspondence	

Details of Claimant		
Name of Claimant *(as per NRIC/Passport)*		
NRIC Number	Date of Birth *(dd/mm/yyyy)*	
Contact Number	Email	
Home Address		
Occupation (For minor claimants, please provide the insured's details.)		Are you self-employed? ☐ Yes ☐ No
Name of Employer	Address of Employer	

Other Insurance

Insurance Coverage Details			
Do you have any other insurance that will cover this loss? If Yes, please state: ☐ Yes ☐ No			
Name of Insurer	**Policy Number**	**Type of Policy**	**Amount Claimed**

Have you ever made a claim under any Personal Accident policy before? If Yes, please state: ☐ Yes ☐ No			
Name of Insurer	**Date of Claim**	**Description of Injury**	**Amount Claimed**

Details of Accident

Accident Information	
Date of Accident *(dd/mm/yyyy)*	Time of Accident ☐ a.m. ☐ p.m.
Place of Accident (Full address)	
How did the Accident occur?	
Nature and Extent of Injury Sustained	

Were there any witnesses to the Accident? If Yes, please state: ☐ Yes ☐ No		
Name of Witness	**Relationship to Insured**	**Contact Number of Witness**

Medical Expenses and Weekly Income Benefit (if applicable)

Medical Information		
Name of Hospital/Clinic	☐ Inpatient ☐ Outpatient	
Admission/Visit Date *(dd/mm/yyyy)*	Discharge Date *(dd/mm/yyyy)*	
Name of Attending Doctor	Specialty of Attending Doctor	
Did you need to stay in the intensive care unit (ICU) of a hospital? If Yes, please state:		☐ Yes ☐ No
ICU Admission Date *(dd/mm/yyyy)*	ICU Discharge Date *(dd/mm/yyyy)*	
Did you require the assistance of a mobility aid or prosthesis as prescribed by a medical practitioner? If Yes, please state:		☐ Yes ☐ No
Type of mobility aid or prosthesis	Rental Period or Purchase Date	

Documents required (attach copies):
☐ Copy of Claimant's NRIC/Birth Certificate
☐ Final Medical/Hospital Bills and Invoices
☐ Medical Reports/Memos stating the nature of injury
☐ Inpatient Discharge Summary, if you were hospitalised
☐ CPF/Medisave Deduction Letter including HRN no. (If claiming for amounts paid using Medisave)
☐ Prescription from medical practitioner for mobility aid or prosthesis (For Mobility Aid & Prosthesis)
☐ Rental or purchase invoice of mobility aid or prosthesis, if any (For Mobility Aid & Prosthesis)
☐ Salary slips for the 12 months immediately preceding the date of accident (For weekly income benefit)
☐ Medical Certificates (For weekly income benefit)

Bills/MC Listing (Please print additional sheet as required)

List of Medical Certificates (Weekly income benefit)			
Medical Certificate No.	**From (DDMMYYYY)**	**To (DDMMYYYY)**	**Type of MC E.g. Hospitalization (HL) / Outpatient (OP) / Light Duty (LD)**

List of Medical Expenses (Including Mobility Aid & Prosthesis)			
Date of Visit	**Tax Invoice no.**	**Name of Hospital/Clinic**	**Amount Paid (specify currency)**

List of Admission details (Recuperation Benefit / ICU Recuperation Benefit)				
Tax invoice No	**From (DDMMYYYY)**	**To (DDMMYYYY)**	**Type of Ward (As per admission tax invoice)**	**Diagnosis (As per inpatient discharge summary)**

Death and Permanent Disablement (if applicable)

Permanent Disablement	
Description of Disability	
Date of Diagnosis/Confirmation	
Impact on Employment/Occupation	
Did the permanent disablement cause you to suffer from Post-Traumatic Stress Disorder (PTSD), which requires counselling services as prescribed by a Medical Practitioner? If Yes, please state:	☐ Yes ☐ No
Name of Medical Practitioner	
Type of counselling services prescribed	Frequency of counselling services prescribed
Do you require necessary modifications to your home or vehicle to help you move around, due to the permanent disablement? If Yes, please state:	☐ Yes ☐ No
Details of modifications to home or vehicle	
Description of how the modifications assist with mobility	
Do you require a caregiver to assist with daily living activities due to the permanent disablement? If Yes, please state:	☐ Yes ☐ No
Scope of assistance required	
Documents required (attach copies): ☐ Medical Reports/Memos stating the nature and extent of disablement ☐ Salary slips for the 12 months immediately preceding the date of accident ☐ Statement from Employer about the impact of disablement on employment ☐ Medical Reports/Memos stating diagnosis of PTSD, if any ☐ Details of prescribed counselling services for PTSD, if any ☐ Detailed invoice of modifications to home or vehicle, if any ☐ Proof of completion of modifications (e.g. receipts, photographs) ☐ Caregiver employment contract, service agreement and invoice, if any	

Accidental Death		
Date of Death *(dd/mm/yyyy)*	Time of Death ☐ a.m. ☐ p.m.	
Cause of Death (as per medical report)		
Relationship of Claimant to Deceased		
Was the deceased travelling as a fare-paying passenger on a public conveyance at the time of the accident? If Yes, please state:		☐ Yes ☐ No
Type of public conveyance	Operator/Company of public conveyance	
Documents required (attach copies): ☐ Death Certificate ☐ Medical Reports/Memos stating the cause of death ☐ Proof of Claimant's relationship to the deceased ☐ Police Report, if any ☐ Travel ticket, boarding pass, or proof of travel, if applicable		

Declaration & Payment Details

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 suppression, concealment, or untrue averment, the Policy shall be void as against the Company, and my right to compensation the absolutely forfeited. Important Notice The insured person must, in the event of a claim, advise the company as to any other insurance that they may have covered 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 any 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, or intermediaries, within or outside Singapore, my/our personal data for the purpose of processing/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.

Payment Mode and Details
☐ **PAYNOW (only by NRIC/UEN)** Please indicate payee's NRIC/UEN No: _____ and **provide a copy of NRIC/ACRA for our verification**. Please ensure that PayNow is linked to NRIC/UEN. ☐ **GIRO** Please complete our GIRO Direct Credit Authorization Form together with a PDF copy of your bank statement showing the name and account number for our verification.

Name (Claimant): _____

Signature(Claimant): _____ Date: _____

Name (Policyholder): _____

Signature(Policyholder):_____ Date: _____

Medical Report – To be completed by Attending Physician

Name of Patient	NRIC of Patient

Are you the Patient's usual Medical Doctor? ☐ Yes ☐ No
If yes, state reasons for previous treatment(s):

Date of First Consultation *(dd/mm/yyyy)*

Was the Patient referred to you by another Physician? ☐ Yes ☐ No
If yes, state Name and Clinic/Hospital of the Referral Physician:

Describe the Nature and Extent of Injuries sustained

In your opinion, explain if the injuries consistent with the circumstances of the accident?

State, in detail, the final diagnosis of the injuries

State details of the first treatment sought by the patient after the accident

Is the patient now, or was the patient at the time of the accident, suffering from or affected by any physical infirmity, disease, or illness, irrespective of the injuries? ☐ Yes ☐ No
If yes, state the nature, and the extent it impedes/will impede the recovery of the patient

Is the patient suffering from or has the patient suffered from any cardiac affection, gout, rheumatism, or fits of any kind? ☐ Yes ☐ No
If yes, state details and if the accident could have been directly or indirectly be caused by the medical conditions above:

Did the Injury require:

☐ Hospitalisation (Period of Hospitalisation: _____ to _____)

☐ X-rays

☐ Special Diagnostic Procedures (State Details: _____)

☐ Surgery (State Details: _____)

Are there any follow-up treatments required for the injury? ☐ Yes ☐ No
If yes, provide details of the follow-up treatments needed

Will the patient's injury prevent the patient from working? ☐ Yes ☐ No
If yes, state reasoning

Will the patient suffer temporary partial or total disablement? ☐ No ☐ Yes, Partial ☐ Yes, Total
If yes, state the extent and expected duration of disablement:

In your opinion, was the patient fully sober at the time of the accident? ☐ Yes ☐ No
If no, provide details:

Please Provide:
☐ Medical Reports/Memos stating nature and extent of injury
☐ Diagnostic Test Results
☐ Surgery/Procedure/Treatment notes, if any

Giro Direct Credit Authorization Form

This form must be completed by the client of Tokio Marine Insurance Singapore Ltd. Payment will be credited directly into your designated bank account stated below. Please complete Part 1 of the form and obtain your bank's confirmation in Part 2. ***If your bank's confirmation is not obtained, for verification purpose, please send us a PDF copy of a blank cheque or the top portion of your bank statement showing the name and account number, failing which we are not able to process the Giro payment to you.***

The completed form and documents may be returned by post to:

Tokio Marine Insurance Singapore Ltd.
20 McCallum Street #09-01
Tokio Marine Centre
Singapore 069046.
Attention:

PART 1 To be completed by the client of Tokio Marine Insurance Singapore Ltd.

Client's Name and Address:

_____ Telephone No :_____
_____ Fax No :_____
_____ Email Address:_____
_____ Contact Person:_____

Particulars of the client's Bank account (Bank no. and Branch no. can be found after cheque no.)

Name of Bank_____
Bank no._____ Branch no._____
Bank account number _____
Bank account name_____

I/We hereby authorize Tokio Marine Insurance Singapore Ltd. to credit payments due to me/us to the above account. Amounts so credited would constitute valid discharge of obligations due to me/us

This authorization shall continue in force until I/we have expressly revoked it by notice in writing delivered to you.

In the event of a change of bank account, I/we shall inform you in writing 30 days in advance before the change.

_____ _____
Date Authorized Signature & Company Stamp (as in bank records)

PART 2: Please obtain the below confirmation from your Bank specified above.

To: Tokio Marine Insurance Singapore Ltd.

We hereby confirm that the signature (s) affixed in Part 1 above and the particulars of the bank account are consistent with the Bank's record.

_____ _____
Name of Bank & Official Stamp Authorized Signature & Date