Tokio Marine Insurance Singapore Ltd.
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Personal Accident Claim Form

The issue of this form is not to be taken as an admission of liability by the Insurer. This form must be completed and returned within thirty (30) days of receipt.

Insured

Policy No: _____ Claim No: _____

Name of Policyholder : _____

Name of Insured Person: _____

Age: _____ IC No: _____ Occupation: _____

Address: _____

_____

Contact Person Name: _____ Position: _____

Tel: _____ Email: _____

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

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: _____

Declaration: I/We hereby declare and warrant that all the answers given above to be true. I/We 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.

Signature of Insured & Company's Stamp : _____ Date : _____

Name : _____

MEDICAL REPORT - TO BE COMPLETED BY ATTENDING PHYSICIAN

Name of Patient: _____

IC 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 : _____