Tokio Marine Insurance Singapore Ltd.
Unit A1 & A2, 1st Floor, Hau Man Yong Complex, Simpang 88,
Kg Kiulap BE1518
Negara Brunei Darussalam
Tel : 2236108 / 2236109 / 2236100
Fax : 2236102

Workmen's Compensation Accident Claim Form

The issue of this form is not to be taken as an admission of liability by the Insurer.

Employer Information

Policy No: _____ Claim No: _____

Policyholder: _____

Business: _____ Total Number of Employees: _____

Address: _____

_____

Contact Person : _____

Tel No : _____ Email : _____

Do you have any other insurance that cover this loss? ☐Yes ☐No

If yes, please provide details: _____

The Injured Person

Name : _____

Age: _____ IC/Passport No: _____ Gender : ☐Male ☐Female

Occupation : _____

No of working days per week : _____ Nationality: _____

What was injured doing when accident happened: _____

Is injured your employee? ☐Yes ☐No If Yes, employment date: _____

If No, who is injured's employer & relationship with you _____

_____

Has injured been medically examined: ☐Yes ☐No If No, why? _____

_____

Name of hospital (or clinic) taken to: _____ ☐Inpatient ☐Outpatient

Date Admitted : _____ Date Discharged : _____

Has injured returned to work? ☐ Yes _____

☐ No, estimated period of disablement _____

Can injured do partial work? ☐Yes ☐No

Are you satisfied that injured met with a bona fide accident of employment? ☐Yes ☐No

Nature/Region of Injury: _____ on the ☐ Left ☐ Right

For fatal accident:

1) Furnish copy of Death Certificate

2) Will an enquiry be held? ☐Yes ☐No

The Accident

Date: _____ Time: _____ Place: _____

When were you notified of accident? _____

Who notified you of accident? _____
(If in writing, please attach to this form)

Date injured actually ceased work _____

Explain the accident in detail:

_____

_____

_____

If machinery used, state what machinery _____

Was injured under the influence of drugs or alcohol at the time of accident? ☐Yes ☐No

Was injured guilty of any misconduct or disobedience to order or rules? ☐Yes ☐No

If Yes, give details _____

Whose neglect caused accident? _____

Any witnesses to the accident? ☐Yes ☐No If yes, Witness Name/Tel: _____

_____

Was accident reported to Commissioner for Labour? ☐Yes (please attach a copy of Form A) ☐No

Month/Year	Basic Wages	Overtime, Bonus, Value of free quarters, Other allowances
Total		
Total including all allowance		

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.

Employer's Signature
& Company Stamp : _____ Date : _____

Name : _____

General Documents Required:

a) Copy of injured employee's identity card
b) Copy of injured employee's passport and page showing sponsorship
c) Copy of employment contract
d) Copy of Bur 500 / 555
e) Copy of past six months salary slip
f) Original Sick Certificates
g) Original Medical Receipts
h) Copy of Police Report (if required)
i) Death Certificate (if required)
j) Copy of Labour Form A