Great Eastern General Insurance Limited (Reg. No. 1920 00003W) (A wholly-owned subsidiary of Great Eastern Holdings Limited)
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WORK INJURY COMPENSATION INSURANCE CLAIM FORM

Agency:	Contact No.:	Email address:	
 The giving of the undermentions This form is sent without prejudi This form is to be completed an 	eived by the employer concerning the accident to	son is making, or will make, a claim.	ıble.
THE EMPLOYER			
Name of Policyholder:		Policy No:	
Business:	Contact No.:	Email:	
Address:			
THE INJURED PERSON			
Name:	Nationality:	Date of Birth: Gender:	
Local Address:			
When did the injured person enter y	our service?		
Work in which the injured person is	usually employed:		
Was the injured person engaged in	the above work when the accident occurred	?	
Is the injured person, your direct er	nployee, contractor's employee or a sub-cor	ntractor?	
Name of hospital taken to:		In or out-patient:	
State whether still in hospital, or dat	e discharged:		
Has the injured person been medica	ally examined? If so, please send report. If no	ot, was free medical examination offered?	
State whether returned to work, and	if so, when?		
The injured worker works a five or five	ve and a half day week or alternate Saturday:		
Are you satisfied the injured person	has met with a bonafide accident arising out	of his/her employment?	
Is the injured person able to do part	ial work?		
What is the probable period of disab	plement (approximate)?		
THE ACCIDENT			
Date:	_ Time:Place	ə:	
On what date did you receive notice	e of accident and from whom? If in writing, p	lease attach to this form:	
On what date did the injured persor	a actually cease work?		
Briefly describe what was the cause	e of the accident and how it happened.		
If from machinery or gearing (a) Was it fenced or guarded. (b) Was it being cleaned whilst in mo	otion?		
Briefly describe the nature of injury s	sustained.		
What was the general nature of the	contract or work going on?		

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Where amputation is invo	olved, please state precisely at	which phalanx/part was amp	utated and state	left or right side			
, ,	under the influence of drink or o						
State through whose ne	glect the accident occurred, if a	ıny:					
State the name of any	persons who witnessed the ac	cident:					
Has the accident been re	eported to the Commissioner fo	or Labour and Police? State v	when and where	,			
_	lars for FATAL CASES of dependents? State names, ac	_					
	death he held? If an place a						
	death be held? If so, please s a Medical or the Post Mortem C		•				
Accident, or wages earne engaged. Note:- The object of th	the Injured Person earned IN The during such shorter period as is form is to ascertain the exact and absent from work at any time.	he/she may have been in the	Employer's serv	ice, stating the date on w	which he/she was		
		WAGE		Bonus, Value of Free Quarters & any other			
YEAR	MONTH	\$	cts	Allowance \$	cts		
	TOTAL						
DECLARATION AND CO	DNSENT	l otal includ	ing all allowances				
We hereby declare that the p the same claim shall make ar void and all rights to recover to In addition to the declaration (collectively, the "Companies"	particulars stated above are true and my false or fraudulent statements or su thereunder in respect of past or future provided above, we hereby represently), as well as their respective represents on all data to the Companies' authorical authorical provided above.	uppress conceal or falsely state and claims shall be forfeited. In that the relevant employees have sentatives and agents collecting,	ny material fact what we agreed and consusing, disclosing a	atsoever the relevant insurar sented to the Company, its r nd sharing amongst themse	related corporations elves their personal		
These purposes are set out in the relevant employees have	n Great Eastern's Privacy Statement, read and understood.	which is accessible at http://www.	.greateasternlife.co	m/sg/en/pncpolicies.htm and	which I/we confirm		
Signature of Employer:		Company's Stamp: _					
Name:	lame: Designation:						

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Date: ___