

# Personal Accident Or Sickness Claim Form

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PLEASE COMPLETE ALL SECTIONS TO FACILITATE THE PROCESSING OF YOUR APPLICATION

The form must be completed truthfully and accurately.

The completed form should be returned together with all supporting documents as soon as possible to the following address:

Chartis Singapore Insurance Pte. Ltd.  
CHARTIS Building, 78 Shenton Way, #07-16, Singapore 079120

The acceptance of this Form is NOT an admission of liability on the part of Chartis Singapore Insurance Pte. Ltd. ("the Company"). Any documentary proof or report required by the Company shall be furnished at the expense of the Policyholder or Claimant.

Any information collected or held by Us whether contained in the Application / Proposal or Claim Form or otherwise obtained in any other manner, may be used and disclosed to Our associated individuals / companies or any independent third parties (within or outside Singapore) for any matters related to your claim and to communicate with You for any purpose.

## Part I (To be completed by Insured or Claimant if Insured is a minor)

|   |  |  |                               |
|---|--|--|-------------------------------|
| Name of Insured   | Nationality :<br>Social Security No. (For US Citizen): |  | Type of Policy and Policy No. |
| Address   | Age  | Sex                                      | Tel. No. (Home and Office)    |
| 1. Present occupation (if more than one, state all).  |  |  |                               |
| 2. Exact nature of occupational duties and monthly earnings   |  |  |                               |
| 3. Name, address of business or employer  |  |  |                               |
| 4. Date & time of accident or inception date of sickness  |  |  |                               |
| 5a. Give full description of injury or sickness from which you are now suffering. If an injury, tell where and how it happened.   |  |  |                               |
| 5b. If you had a history of similar illness and/or injury, which you have experienced in the past, please give details as to when, where and from whom you received medical diagnosis, treatment, consultation or prescribed drugs. |  |  |                               |
| 6. Name and address of doctor(s) who treated you and consultation date(s).  |  |  |                               |
| 7. Details of hospitalisation: (Please attach hospital bill)<br>(a) Name of hospital<br>(b) Period of hospitalisation   |  |  |                               |
| 8. Date on which you last worked prior to disability or sickness.   |  |  |                               |
| 9. Date on which you returned to work.  |  |  |                               |
| 10. Date on which you expect to return to work if you have not already done so.   |  |  |                               |
| 11. How long have you been totally or partially disabled from engaging in or attending to your usual business as the result of the injuries or sickness?  |  |  |                               |
| 12. Name and address of any witness of the incident.  |  |  |                               |
| 13. Name and address of your usual physician.   |  |  |                               |
| 14. Are you making any other Insurance or compensation claim as a result of this injury or sickness?  |  | If yes, state: Name of Insurance Company | Policy No.                    |
|   |  | Amount of Benefits                       | Date Insurance Effected       |

I, the undersigned, do hereby declare that to the best of my knowledge and belief, the foregoing particulars are true and correct

\_\_\_\_\_

Date

\_\_\_\_\_

Signature

In the event of the insured being unable to sign the form, it should be completed and signed by a near relative or other responsible person in charge of the insured during his/her disability. In such event, the signatory must state his/her name, address and relationship to the insured.

### Authorisation

I hereby authorise any hospital doctor or other person who has attended me to furnish Chartis Singapore Insurance Pte. Ltd. or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription or treatment and copies of all hospital or medical records. I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

\_\_\_\_\_

Name:

\_\_\_\_\_

I/C No.:

\_\_\_\_\_

Date:

\_\_\_\_\_

Signature:

Particulars of Agent  
Name:

Mobile:

Email Address:

## Part II (Attending Physician's Statement)

|   |  |
|---|--|
| Name of Patient   | I/C No.  |
| 1. Date on which you first saw the patient.<br>Is condition due to injury or sickness?  |  |
| 2. Was the patient referred to you by a general practitioner?<br>If so, please indicate his/her name and address.   |  |
| 3. Of what symptoms did the patient complain?<br>When did patient first consult you for this condition?   |  |
| 4. (a) According to the patient, how long had he/she been experiencing these symptoms?<br><br>(b) How long do you feel the symptoms had lasted?   |  |
| 5. Had the patient previously seen any other doctor on account of these symptoms?<br>If so, please give details.  |  |
| 6. (a) What was your diagnosis?<br><br>(b) Did you inform the patient of your diagnosis and has any treatment been recommended? If so, when did you do so?  |  |
| 7. Did injury or sickness require:<br><br>(a) hospitalisation?<br><br>(b) X-rays?<br><br>(c) Special diagnostic procedures?<br><br>(d) Surgery?   | (a) <input type="checkbox"/> Yes      Date Admitted _____ Date Discharged _____<br><input type="checkbox"/> No<br><br>(b) <input type="checkbox"/> Yes <input type="checkbox"/> No<br><br>(c) <input type="checkbox"/> Yes <input type="checkbox"/> No<br><br>(d) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Is the patient still under your care for this condition?   |  |
| 9. Bearing in mind the patient's occupation as stated overleaf, do you feel that the injuries or sickness would have prevented him from working?  |  |
| 10. How long was, or will the patient be continuously totally disabled (unable to work)?  |  |
| 11. How long was, or will the patient be partially disabled?  |  |
| 12. Give details of any circumstances, such as intoxication, physical defects or medical history which may have contributed to the accident or sickness and/or lengthen the period of disability. |  |
| 13. Whether injuries sustained will result in any permanent disablement/incapacity. If so, please advise percentage of disablement/incapacity.  |  |

I hereby certify that I have personally examined and treated the patient for the above \*injuries/sickness and that the facts as given above present my opinion of his/her condition.

|                    |                |
|--------------------|----------------|
| Name of Physician: | Signature:     |
| Address:           | Date:          |
| Tel. No:           | Qualification: |

\*to delete as applicable

NB: No claim can be admitted unless medical certificate from a duly qualified and registered medical practitioner on the form above is furnished at the expense of the Insured.

Chartis Singapore Insurance Pte. Ltd.  
CHARTIS Building, 78 Shenton Way, #07-16, Singapore 079120  
Tel: 6419 3000  
Co. Reg. No. 201009404M

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