

Group Personal Accident Claim Form

Part I and II (on the reverse side) of this form must be completed in full.
 The Company reserves the right to require or to obtain further information should it deemed necessary.

Part I (To be completed by Claimant)

A. Particulars			
Name of policyholder	Policy no.	Membership no.	
Name of employee	Date of employment	Date of birth	Sex <input type="checkbox"/> F <input type="checkbox"/> M
Occupation	List exact nature of occupational duties		
Name of covered member (if dependant of employee)	Dependant's date of birth	Marital status	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child
B. Details of accident			
1. Date and time of accident			
2. Nature of accident (state in details, how and when it happened.)			
3. Describe in details the injury sustained, indicating the area and type of injury (eg. Fracture, cut, bruise, etc.)			
4. Did you consume alcohol or drug prior to the accident? If 'yes' in what quantity?			
5. Name and addresses of all doctors who treated you for the injury.			
<u>Name</u>	<u>Address (es)</u>	<u>Date Consulted</u>	
C. Details of disability			
6. Details of hospitalisation, if any (a) Name of hospital (b) Period of hospitalisation			
7. Date last worked prior to disability			
8. Date returned to work			
9. Date expected to return to work if you have not already done so.			
10. If after your return to work, you were not be able to perform all your duties immediately, indicate: (a) Date returned to work (b) Details of duties NOT able to perform immediately (c) Date which all duties were fully performed			
D. Others			
11 Are you presently insured for accident benefits with other companies? If so, please state			
<u>Name of insurance company</u>	<u>Amount of benefit</u>	<u>Date of insurance</u>	
Declaration and authorisation			
I hereby declare that the statements and answers given above are true and complete to the best of my knowledge and belief and that I have not made any false or fraudulent statement, any suppression and concealment of facts. I hereby authorise any hospital, doctor or other person who has attended to me or examined me for any reason, to disclose to HSBC Insurance (Singapore) Pte. Limited any and all information with respect to any illness or injury and, to provide HSBC Insurance (Singapore) Pte. Ltd copies of all hospital or medical records, including prior medical history. A Photostat copy of this authorisation shall be considered as effective and valid as the original.			
_____ Employer's signature / Company's stamp		_____ Signature of claimant	
Name :		NRIC No. :	
Designation :		Date :	

PART II - Medical certificate (To be completed by the doctor at Patient's Expense)

Name of Patient	Age	NRIC No.	Date of Accident
1. Describe the cause and extent of injury, stating the anatomical site involved.			
2. Present condition of the injury.			
3. Does the injury result in the PERMANENT total loss of use of the area involved? If so, please state the extent of such involvement.			
4. Treatment administered (such as number of stitches, physiotherapy, type of dressing, etc)			
<u>Date</u>	<u>Time (am/pm)</u>	<u>Treatment</u>	
5. Names and addresses of other doctors who attended to the Patient for the same injury			
<u>Name</u>	<u>Address</u>	<u>Approximate date</u>	
6. Did the injury require :			
(a) Surgery? Yes / No			
(b) X-ray? Yes / No			
(c) Hospitalisation? Yes / No Date admitted : _____ Date discharged : _____			
7. (a) Was healing complicated? Yes / No			
(b) If so, state why and any special treatment given			
8. Bearing in mind the patient's occupation as stated overleaf, do you feel that the injuries would have prevented him from working?			
9. If your answer to the above is 'YES', please state how long will the patient be totally or partially disabled from engaging in or attending to usual business as the result solely of the injuries.		Totally from _____ to _____	
		Partially from _____ to _____	
10. If an absence from work of more than 2 weeks was necessary, please describe in detail the reasons why you feel the patient could not return to work earlier.			
11. Give details of any circumstances, such as intoxication, physical defects or medical history which may have contributed to the accident and/or lengthen the period of disability.			
I hereby certify that I have personally examined and treated the Patient for the above injuries and that the facts as given above represent my opinion of his/her condition.			
Name : _____		Signature : _____	
Professional qualification : _____		Date : _____	
Address : _____			