Personal Accident

Claim Form

SG020

CHUBB®

Important Notes

This claim form is to facilitate your claim in the event of you or a member of your family is confined to hospital while being Insured under a Personal Accident policy.

You can help to avoid unnecessary delay in processing your claim by ensuring that:

1) Sections A to G are fully completed and signed by the Insured and/or Claimant. Please attach the Detailed Pre-Medical/Final Hospitalisation/Post-Medical Report/a copy of the Inpatient Discharge Summary to the Claim Form.

2) Section H is completed by the Claimant's Attending Physician. Please note that you or the Claimant is responsible for any expenses incurred in obtaining medical evidence in support of the claim.

The issue and acceptance of this form and its accompanying documents (if any) does NOT constitute an admission by Chubb Insurance Singapore Limited (Chubb) that any part or the whole of the Claimant's claim is accepted. It also does not constitute a waiver of Chubb's rights in accordance with the terms and conditions of the Policy.

Section A: Particulars of Policyholder/Insured Person and Claimant

Name of Policyholder/Insured Person (As shown in NRIC/Passport):

The Scout Association of Australia, New South Wales Branch

Address of Policyholder/Insured Person:

Quad 3, Level 1, 102 Bennelong Pkwy

Sydney Olympic Park NSW Postal Code: 2127

Policy No(s): 93101214

Period of Insurance: From: 30/11/2023 To: 30/11/2024

NRIC/Passport No.: Date of Birth:

Nationality: Age:

Tel No. (Mobile): Gender: ☐ Male ☐ Female

Tel No. (Office): Tel No. (Residence):

Occupation: Email:

Date of Employment: Name of Intermediary (If any):

Name of Employer:

Name of Claimant (As shown in NRIC/Passport) - if different from Insured Person:

Address of Claimant:

Postal Code:

NRIC/Passport No.: Date of Birth:

Nationality: Age:

Tel No. (Mobile): Gender: ☐ Male ☐ Female

Tel No. (Office): Tel No. (Residence):

Occupation: Email:

Date of Employment: Relationship to Insured:

Name of Employer:

Section B: Payment Details

Please provide details for payment of your claim in the event that the claim is deemed payable by Chubb.

I hereby authorise and request Chubb to pay benefit due in respect of this claim as follows (Name as per Identification Card and/or Bank Account):

☐ **Electronic Funds Transfer** - For payments in SGD and to bank accounts in Singapore (Recommended)

Payee Name (As per bank account name):

Name of Bank:

Branch Code No.: Account No.:

Note:

- You can receive the remittance within 3-5 days upon approval of claim.
- If no name is provided, settlement will be effected to the payee as provided for under the terms of the policy.

Important Notice:
Chubb shall (i) be discharged from all liability under this claim and (ii) not be liable for any and all losses incurred by you, as a result of you providing Chubb with an incorrect bank account number under this section for the payment of this claim.

Section C: Details of Accident

Please enclose a copy of Police Report if accident is due to road traffic accident.

Date of the Accident: Time of the Accident (24-Hour):

Country of Accident:

When and Who discovered the Accident:

Relationship of person to the Insured:

Were there witnesses to the incident? ☐ Yes ☐ No

If **Yes**, please provide details below

	Witness 1	Witness 2
Name:		
Address:		
NRIC:		
Contact Number:		

Is this a job-related accident? ☐ Yes ☐ No

Has this accident been reported to the Ministry of Manpower (MOM)? ☐ Yes (please attach a copy of the I-REPORT) ☐ No

If **No**, please state reason(s) the accident was not reported to the MOM:

Was the Insured (if a motorcyclist) wearing a helmet at the time of the traffic accident? ☐ Yes ☐ No

Was the Insured under the influence of alcohol, medication, drugs or any other intoxicating substance at the time of accident? ☐ Yes ☐ No

If **Yes**, please provide details below (Please use supplementary sheet if necessary)

Name/Type of Alcohol, Medication, Drugs or Intoxicating Substances	Quantity Consumed	Date and Time Consumed

Chronology and Description of the Accident (Please use supplementary sheet if necessary)

Section D: Nature of Injury

Describe in detail the injuries sustained, indicating the part(s) of body injured and its type of injury (Eg. Fracture, Cut, Bruise, etc).

Name and Address of Doctor(s) whom treatment was received from and the Consultation Date(s):

Name and Address of usual physician:

Details of Hospitalisation (Please attach In-Patient Discharge Summary and Original Final Hospital Bill)

Name of Hospital:

Period of Hospitalisation: From: To:

Details of Temporary Disability from Engaging in or Attending to your Business as a Result of the Injuries

Light Duties: From: To:

Medical Leave: From: To:

Date returned/expected to return to work:

Will there be more medical bills to be submitted at a later date? Yes No

Are the medical expenses claimable under the Work Injury Compensation Act? Yes No

Section E: Retrenchment/Termination Benefit Claim

Name of Employer:

Date of Employment: Date of Retrenchment/Termination:

Employment Type: Permanent Contract Temporary

Reason for Retrenchment/Termination:

Section F: Any Other Insurance

Are you claiming from any other insurance company or other sources in respect of injury or illness? If Yes, state:

Name of Insurance Company	Policy No.	Amount of Benefits	Date Insurance Effected

Section G: Declaration

Did you remember to enclose the following? (Where applicable)

Document	Yes	N/A
Traffic Police Report (If involved in Road Accident)	☐	☐
Medical Bills	☐	☐
Written notes from Physician on type of injury sustained/Inpatient Discharge Summary or Medical Report	☐	☐
Cover Letter stating personal particulars, contact details, and policy information (If any)	☐	☐
Retrenchment/Termination Letter from Human Resource Department stating employment details (Please include a copy of your CPF Contribution History Statement for the period of unemployment)	☐	☐

By signing this form, I/We agree that Chubb will use the information supplied here and during the formation and performance of my policy, for policy administration, customer services, claims handling and fraud analysis and prevention, and that Chubb may disclose such information to its service providers, agents, authorities and other parties for these purposes.

I/We hereby authorise any hospital, physician, and any other person or entity who has attended to or examined me, to furnish to Chubb or its authorised representatives, any and all information with respect to any illness or injury or loss, medical history, consultation, prescriptions or treatment, copies of all hospital, medical or other records, investigation status and results, and such personal information as Chubb in its absolute discretion considers relevant for its assessment of my claim. A photostatic copy of this authorisation shall be considered as effective and valid as the original.

I/We do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I/We agree that if I/We have made or in any further declaration or representation shall make any false or fraudulent statements or suppress, conceal or falsely state any fact whatsoever the Policy shall be void and all rights to recover thereunder in respect of past, present or future claims shall be forfeited.

Signature of Policyholder (Please affix company stamp if applicable)

Date

Signature of Claimant (If different from Policyholder)

Date

Name of Insured's Direct Manager (For corporate policies)

Signature of Insured's Direct Manager (For corporate policies)

Date

Note:

Kindly submit the completed claim form through your Broker or via email to A&HClaims.SG@Chubb.com. Please ensure that the relevant supporting documents are submitted as well.

Contact Us

Please visit our website at www.chubb.com/sg or contact us at +65 6398 8000.

Section H: Attending Physician's Statement (To be completed by attending physician)

Name of Patient:

NRIC/Passport No.: Gender: Male Female Date of Birth:

Date on which you first saw the Patient:

Is it due to Sickness or Injury? Sickness Accident on:

Was the Patient referred to you by another doctor? If so, please furnish with Name and Address of Referral doctor

Name of Doctor

Address

What symptoms did the Patient complain of?

According to the Patient, how long had he/she been experiencing these symptoms?

In your opinion, how long do you feel the symptoms had lasted?

Had the Patient previously seen any other doctor or receive treatment on account of these symptoms? Yes No
If **Yes**, please give details

What was your final diagnosis?

Does the injury result in fracture of bones? Yes No
If **Yes**, please state which part(s) of the body

Has the Patient previously suffered from an injury on the same part? Yes No

Did the injury or sickness require:

Hospitalisation? Yes No (Please state period of hospitalisation: From: To:)

X-rays? Yes No

Special diagnostic procedure? Yes No

Surgery? Yes No (Please specify type of surgery:)

Is the Patient still under your care for this condition? Yes No

Bearing in mind the Patient's occupation as stated overleaf, do you feel that the injuries or sickness would have prevented him/her from working? Yes No

And why?

How long was or will Patient be continuously totally disabled (Unable to work)?

How long was or will Patient be partially disabled?

Give details of any circumstances, such as the influence of alcohol, drug or any other intoxication substance, physical defects or medical history which may have contributed to the accident or sickness and/or lengthen the period of disability.

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

Name of Physician

Qualification

Official Address:

Tel/Fax:

Signature with Official Stamp

Date

Please click on the button to submit your claim form: Submit

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