Claim Form

Liberty Specialty Markets

WORKPLACE PROTECT

Important Notice

This form is issued without admission of liability under the Policy. If a workplace injury occurs, you must submit this form immediately.

Each question must be answered in full. A failure to comply with this requirement may prejudice any claim you make.

You must immediately send Liberty Specialty Markets (Liberty) any correspondence received from lawyers acting for the injured worker. Further, you must not, make any admission of liability whatsoever.

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1. EMPLOYER/POLICYHOLDER'S DETAILS

Policy holder

Telephone | Fax

Email | Policy number

Are there any other policies that may cover you for this accident? Yes ☐ No ☐

Is your company GST registered? Yes ☐ No ☐

If so, please confirm if you are claiming GST chargeable on the medical expenses from IRAS. Yes ☐ No ☐

Please provide us with the Insured's banking details for the payment of medical and loss wages:

Beneficiary full name

Bank name | Swift code

Branch code ☐☐☐ Bank code ☐☐☐☐ Account no ☐☐☐☐☐☐☐☐☐☐☐☐☐

2. INJURED WORKER'S DETAILS

Name

Gender Male ☐ Female ☐ | Date of birth

Citizenship | NRIC/FIN/Passport No.

Home address

If worker is a citizen or resident of the United States, is the Worker eligible for US medicare benefits? Yes ☐ No ☐

3. EMPLOYMENT DETAILS

Is the injured worker your direct employee? Yes ☐ No ☐

If no, please provide details of the injured worker's direct employer

What is the worker's usual occupation?

Basis of the worker's employment Full-time ☐ Part-time ☐ Casual ☐ Other

Number of days worked per week 5 days ☐ 5.5 days ☐ 6 days ☐ Other

When did this worker first commence employment with you?

Did the worker suffer from any pre-existing injury or disability? Yes ☐ No ☐

Please list the actual monthly earnings of the worker for the 12 months preceding the accident		
Month	Gross earnings excluding bonus and overtime	Additional payments/Bonus amounts received
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

4. DETAILS OF THE ACCIDENT

Date Time AM ☐ PM ☐

Date the accident was reported to you

Where did the accident occur?

How did the accident occur?

Did any third party cause or contribute to the accident? Yes ☐ No ☐

If Yes, provide the name and contact details of the third party

Was any person involved in the accident under the influence of liquor/drugs? Yes ☐ No ☐

Was the worker injured due to misconduct or a failure to follow instructions? Yes ☐ No ☐

Name of supervisor Designation

5. INJURIES SUSTAINED BY THE WORKER

Please describe the worker's injuries

Date the worker ceased work?		
Is the worker still undergoing medical treatment?	Yes ☐	No ☐
Has the worker returned to work?	Yes ☐	No ☐
If no, please advise if the worker is on medical leave for more than 30 consecutive days.	Yes ☐	No ☐

(If Yes, please provide copy of the medical certificate)

6. DECLARATION

I/We (print name in full)

(position)

declare that the information shown on this form is true and correct to the best of my/our knowledge and belief and that I/we have not concealed any information relevant to the reported accident.

Signature and stamp of the policyholder Date

Please attach a copy of the MOM incident report

RELEASE AND DISCLOSURE OF MEDICAL INFORMATION

To be completed by the injured worker.

For the purposes of this authorisation, a reference to Liberty Specialty Markets ("Liberty") includes its service providers, representatives and agents.

1. I authorise any hospital, doctor, clinic and other healthcare practitioner who has attended upon or examined me for any reason to:
   a) disclose to Liberty all information with respect to any injury, sickness or treatment (whether the subject of this claim or otherwise); and
   b) provide to Liberty a copy of any medical reports, hospital/clinical records arising from or associated with any such injury, sickness or treatment.
2. I authorise Liberty to disclose my personal information (including medical reports and hospital/clinical records) to any medical practitioner, legal practitioner and any other service provider, expert or consultant for the purpose of determining and managing my claim.
3. A photostat copy of this authorisation shall be as effective and valid as the original.

Signature of the injured worker Date

This policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your policy is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact Liberty Specialty Markets Singapore Pte Limited or visit the GIA/LIA or SDIC web-sites (www.gia.org.sg or www.lia.org.sg or www.sdic.org.sg).

Privacy Notice

Liberty Specialty Markets Singapore Pte Limited (UEN 201538069C) (**Liberty**) is an insurer authorised by the Monetary Authority of Singapore to conduct insurance business in Singapore. It is a member of the United States-based Liberty Mutual Group. Liberty's contact details are:

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Liberty collects personal data, including from insurance brokers, in order to provide its services and products, manage claims and for purposes ancillary to its business. Liberty passes it to third parties involved in this process such as Liberty's related companies, reinsurers, agents, loss adjusters and other service providers. We may store your information with third party cloud or other types of networked or electronic storage providers. Third parties may be located locally or overseas in the United States, Canada, United Kingdom, Hong Kong, Australia and Malaysia. Your information may be transferred to countries without comparable data protection laws if it is reasonably necessary to provide you with the products or services you seek from Liberty. If you do not provide the personal data Liberty or other relevant third parties require to offer you specific products or services, Liberty may not be able to provide the appropriate type or level of service.

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