

HSBC Insurance (Singapore) Pte. Limited

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Company registration no. 195400150N

\*All questions must be fully answered. Dashes are not acceptable.

## A. Assured

Name:			
Address:			
Policy no:	Expiry date:	Tel:	Business:

## B. Injured person

Name:			
Address:			
Sex:	Age:	Nationality:	Number of days worked per week:
Occupation in which the injured person is employed and the department he is working in.		Would such physical defect or infirmity have contributed towards this accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was the injured person engaged in this occupation when the accident occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No		What is the probable period of disablement?	
Is the injured person in your direct employment? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, give name and address of contractor and insurer.		State name of hospital taken to and whether admitted.	
When did the injured person enter your service?		State whether still in hospital, or when discharged.	
State clearly if the injured is casual, permanent or working under contract?		Has the injured person returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when?	
Was the injured person free from physical infirmity at the time of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you satisfied the injured person had met with a bonafide accident of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was the part of the body affected by this accident quite normal before the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, give full particulars.		Is the injured person able to do partial work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		State whether the injured person had sustained any previous injury under your employment. <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please give full particulars.	

## C. Accident

Date:	Time:	Was he guilty of any misconduct or disobedience to orders or rules? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please give full particulars
Place:		
When did you receive notice of accident and from whom?		Describe in detail the injuries sustained indicating the part of body injured and the type of injury.
What was the general nature of the contract or work going on?		
Please state through whose neglect did the accident occur.		Please state the names and addresses of witnesses.
Was the injured person under the influence of drink or drugs at the time of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		Has this accident been reported to the commissioner for labour? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Please forward a copy of notice of accident form to us.



**E. Sign here**

We/I hereby declare that the above statements are true to the best of our/my knowledge and belief, and we/I claim in respect thereof the protection of our/my policy.

Date \_\_\_\_\_

Signature of insured \_\_\_\_\_  
(with company's stamp)

**F. Notice**

1. Insured is requested to state as fully and accurately as possible the information asked for above.
2. If any detail or information is not readily available, please do not delay despatch of this form, but submit further details at a later date.
3. When the injured person returns to work, please send to the company the following documents:-
  - a) Original medical certificates, bills and receipts.
  - b) Copies of all your correspondence to and from the Commissioner for Labour.
4. According to the standing Workmen's Compensation Act, each and every accident occurred to your employee/employees must be reported in writing to the Commissioner for Labour within ten days of the occurrence of the accident, otherwise you may be punished with a fine not exceeding \$2,000.
5. No claim for compensation will be considered unless the aforementioned required documents 3a are submitted and Notice of Assessment issued by the Commissioner for Labour.
6. The acceptance of this form is not in itself an admission of liability on the part of the company.

Please paste a copy of injured's valid work permit within the space provided here under.



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Back



## G. Clinical abstract application Form

### Instructions

1. This form must be fully completed for the application of a medical report. It should be signed by the patient or the patient's parent (if patient below 21 years old of age) or the parent's next-of-kin (if parent is deceased), and be duly witnessed.
2. This form is to be submitted with the appropriate report fee.
3. The release of the medical report is subject to official approval.

### Medical Superintendent

\_\_\_\_\_ Hospital  
Singapore \_\_\_\_\_

I \_\_\_\_\_ NRIC no. \_\_\_\_\_  
(Name)  
of \_\_\_\_\_  
(Address)  
hereby authorise you to furnish \_\_\_\_\_  
(Name)  
of \_\_\_\_\_  
(Address)  
with a medical report on \_\_\_\_\_ NRIC/hospital registration no.\* \_\_\_\_\_  
(Name of patient)  
who was treated at the hospital as a patient in the department of \_\_\_\_\_ from \_\_\_\_\_  
to \_\_\_\_\_

A photostatic copy of this authorisation shall be considered as effective and valid as the original.  
The medical report is required for the purpose(s) specified below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Besides the medical report fee I undertake to pay any additional charges such as X-ray and laboratory investigation charges which may be incurred in the preparation of the medical report

Name (in block letters): \_\_\_\_\_  
Relation to patient: \_\_\_\_\_  
Signature of patient/parent/next-of-kin \_\_\_\_\_

Duly witnessed by:  
\_\_\_\_\_  
(Signature) Name (in block letters): \_\_\_\_\_

NRIC no: \_\_\_\_\_ Address: \_\_\_\_\_

### For official use

Application is approved / not approved

\_\_\_\_\_  
Signature and date Name and designation of approving officer

\* Delete as appropriate