Group Personal Accident Claim Form

Important Notes
The acceptance of this Form is NOT an admission of liability on the part of Zurich Insurance Company Ltd (Singapore Branch) (the "Company"). Any documentary proof or report required by the Company shall be furnished at the expense of the Policyholder or Claimant. The Company reserves the right to request for further information, should it deemed necessary.

Please mail completed and signed claim form to:
Zurich Insurance Company Ltd (Singapore Branch)
50 Raffles Place #29-01
Singapore Land Tower
Singapore 048623

NOTE: All the sections of the claim form are to be completed and marked as "**NA**" if inapplicable.

Part I - Particulars of Policyholder	
Policyholder's Name **SINGAPORE UNIVERSITY OF SOCIAL SCIENCES**	Insurance Policy No. **ZZG8001129SN**
Correspondence Address **461 CLEMENTI ROAD, SINGAPORE 599491**	

Part II - Particulars of Claimant			
Claimant's Name (Insured Person)	Identity Card//Passport No.	Gender ☐ Male ☐ Female	Date of Birth (dd/mm/yyyy) / /
Residential Address		Designation	
Contact No. (H) (O) (HP)		Email Address	

Part III Settlement and bank account details	
(1) Settlement to be made payable to ☐ Policyholder ☐ Claimant ☐ Others ( )	**(3) Bank account details** **[Please ensure that the details are entered clearly and accurately to prevent any delay in the payment]** **Name of Beneficiary (also known as bank account holder)** **Name of Bank**
(2) Mode of payment ☒ GIRO (please provide your bank account details on the right)	**Bank Account Number** **Bank Code**

Part IV Details of Accident		
Country/City of accident/injury	Date of Occurrence (dd/mm/yyyy) / /	Time ☐ am ☐ pm
Description of accident/injury		
Are there any other insurance policies covering you for accident benefits? ☐ Yes ☐ No If "Yes", please specify name of insurer, policy number and amount recoverable Name of Insurer : Policy No. : Benefit Type : Amount Recoverable :		

Have you or the Claimant ever had previous claims on the same injury or a similar condition? ☐ Yes ☐ No
If "Yes", please specify name of insurer, date and amount claimed.

Part V - Type of Claims

☐ Personal Accident ☐ Accident Medical Expenses

Personal Accident (only applicable to accidental death and Permanent Total Disability)

Supporting documents required

- Police report for accident (where applicable)
- Death certificate (certified true copy), autopsy report and coroner's findings (death claim)
- Proof of relationship between deceased and claimant (death claim)
- Evidence of employment (Employment contract and/or certified true copy of pay slip, where applicable)
- Relevant medical reports

Location/Cause of accident

Nature of injury

State amount claimed

Accident Medical Expenses

Supporting documents required

- Police report for accident (where applicable)
- Original medical invoices and receipts showing expenses and diagnosis
- Flight itinerary, boarding pass o passport stamp which shows date of departure and return to Singapore (if injury is sustained overseas)
- Relevant medical reports, inpatient discharge summary (at Claimant's own expenses)

Benefit type ☐ Outpatient ☐ Inpatient

Cause of accident

Nature of injury

State amount claimed

Date of Consultation
/ /

Others
In respect of any other claims, please provide details of the claim you are submitting and provide all relevant supporting documents/proof of event/police reports (where applicable). If the space provide below is insufficient, please attach additional pages.

_____
_____
_____
_____

Part VI - Declaration and Authorization

- I / We hereby declare that all the information and particulars given above are true and complete to the best of my/our knowledge and belief and they are made without reservation of any kind.
- I / We hereby acknowledge, consent and agree that –

  (i) the Company may collect, use and disclose all personal data provided or as may be provided by me/us and through other sources as the Company deem relevant from time to time for the purposes as contemplated in this form including but not limited to policy servicing, processing, handling, administering, claims investigations, claims analysis, fraud evaluation, prevention and control, and/or any work put towards settling my/our claim with the Company or other insurers;

  (ii) the Company may disclose the personal data to third parties (whether in or outside Singapore) including but not limited to consultants, fraud detection agencies, the General Insurance Association and its members, regulators, law enforcement bodies and government agencies and/or authorities for the purposes as set out in this form;

  (iii) the personal data protection clauses herein ("DPC") are not exhaustive. By signing this form, I/we declare that I/we have read, understood and agreed to be bound by the prevailing Personal Data Protection Policy available at http://www.zurich.com.sg/pdpa ("Data Protection Policy") which is to be read together with the DPC. If there is any discrepancy between the DPC and the Data Protection Policy, the DPC shall prevail only to the extent of the discrepancy;

  (iv) if I / we provide third parties' personal data (e.g. information of the life assureds, insured persons, beneficiaries, beneficial owners, dependents, spouse, children, parents, siblings, customers, prospects, payees and/or employees) to the Company, I / we represent and warrant to the Company that prior consents have been obtained from each of the third parties for the collection, usage, disclosure and processing of their personal data in the manner as set out above and the Data Protection Policy; and

  (v) I / We shall indemnify the Company for all losses and damages which may be suffered by the Company arising out of the breach of the declarations, representations and/or warranties herein.

- I / We hereby authorize physician, medical practitioners, hospital, clinics by whom or where I / we have been observed or treated to give full particulars about my/our health to the Company, including prior medical history.
- I / We hereby further authorize any parties, including but not limited to police and government authorities, airlines, travel agents, insurance companies etc who are in possession of my/our insurance proposal information, claim information or any related information to release part or all of the information about the subject or related incidents of injury to the Company.
- A photocopy of this authorization shall be considered as effective and valid as the original.

_____ / /
_____

Signature of Claimant **Date**

ATTENDING DOCTOR'S STATEMENT

Section A: To be completed by the attending doctor	
Name of patient	NRIC/ Passport No.
Date of first consultation	Date of the diagnosis
Was the patient referred to you by a general practitioner? (If yes, please provide us the name/contact number/address)	
What is the cause of the sickness or injury?	
Has the patient ever had the same or similar sickness or injury? If "yes", how long has it existed prior to the date of first consultation?	
What are the symptoms experienced by the patient and how long have they lasted prior to the date of first consultation with you?	
Is there further treatment for the sickness or injury?	

Section B (To be completed only if the injury has resulted or likely to result in disablement)
Would the injury/sickness have prevented the patient to perform the duties of his own occupation?
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?
Please provide us the details of the circumstances, such as intoxication, physical defects or medical history which may have contributed to the accident/sickness and/or lengthen the period of disability.
Does the injury result in permanent disablement or permanent loss of use of any area? If so, please advise on the extent involved.

Section C (To be completed only if there is a fracture)
Is the fracture a ***Simple Fracture** or ****Other Fracture**? _____ ***Simple Fracture** means a fracture in which there is a basic and uncomplicated break in the bone and which in the opinion of a Physician requires minimal and uncomplicated medical treatment. ****Other Fracture** means any fracture other than a Simple Fracture

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

Name : _____ **Signature & Clinic/Hospital Stamp: _____**

Professional Qualification : _____ **Date : _____**

Address : _____