

Personal Accident Claim Submission Checklist

We are sorry to hear of your accident/loss. In order for us to consider your claim, please complete the Personal Accident Claim Form and submit it with the relevant documents listed below within thirty (30) days from the date of occurrence. Thank you.

Please tick the section(s) that you are claiming for	Documents needed
<input type="checkbox"/> Medical Expenses	<ul style="list-style-type: none"> - Original final medical bills/receipts - Any available medical reports/inpatient discharge summary - Copy of police report/road traffic accident report (if applicable) <p>Note: All medical bills must indicate the breakdown of the expenses incurred and the doctor's diagnosis must be clearly stated. We reserve the right to obtain from you additional information.</p>
<input type="checkbox"/> Accidental Death	<ul style="list-style-type: none"> - Proof of relationship between deceased and claimant - Certified true copy of death certificate - Certified true copy of letters of administration/grant of probate (if any) - Copy of police report/road traffic accident report (if applicable) - Certified true copy of coroner's/post-mortem/autopsy report (if applicable)
<input type="checkbox"/> Funeral Expenses	<ul style="list-style-type: none"> - Original invoices
<input type="checkbox"/> Total & Permanent Disablement (TPD)	<ul style="list-style-type: none"> - Medical report (to be completed by attending physician) - Any other available medical reports - Copies of medical leave certificates - Copy of police report/road traffic accident report (if applicable)
<input type="checkbox"/> House Fitting Expenses	<ul style="list-style-type: none"> - At least two (2) home renovation quotations <p>Note: Approval must be obtained from us BEFORE proceeding with renovations.</p>

We would also like to highlight that:

- Any cost of obtaining documents is not reimbursable under the policy.
- Where applicable, all documents must be translated into English.

You may send your claim documents to our office at:

PERSONAL ACCIDENT CLAIMS
Direct Asia Insurance (Singapore) Pte Ltd
88 South Bridge Road
Singapore 058716

If you need any assistance, please call us at **6532 1818** or email us at
Claim@DirectAsia.com

Personal Accident Claim Form

1. Policyholder's Details

* To delete appropriately

Name (as in NRIC/Passport): <i>Mr/Miss/Mrs/Mdm/Dr*</i>		NRIC/Passport number:	Policy number:
Occupation:		Email:	
Contact numbers:			
(O)	(H)	(HP)	

2. Claimant's Details (if Claimant is different from Policyholder)

Name (as in NRIC/Passport): <i>Mr/Miss/Mrs/Mdm/Dr*</i>		NRIC/Passport number:	
Date of birth (dd/mm/yyyy):	Occupation:	Relationship with Policyholder:	

3. Accident Details

Date of occurrence (dd/mm/yyyy):	Place of occurrence:	
Time of occurrence: <i>am/pm*</i>		
Please describe in detail how the accident happened:		
Were there any eye-witnesses to the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please provide their contact details below:		
Name of Witness	Address	Contact No/E-mail Address

4. Injury Details

Please describe the nature and extent of injuries sustained in detail (eg. which part of the body and whether it is a fracture, cut, bruise, etc.):		
When did you become disabled so as to be prevented from doing work? (dd/mm/yyyy)	When did you return to work? If you have not returned to work, please state when you expect to return (dd/mm/yyyy):	
Please provide the name and address of all doctors who attended to your injuries below:		
Name of Doctor and Name & Address of Clinic/Hospital	Date of First and Last Attendance	Diagnosis/Treatment

If you are entitled to claim under any other insurance policy, (eg. other personal accident policies, medical insurance, work injury compensation, etc.), please provide us with the details of those policies:

Insurance Company	Type of Policy	Policy Number	Compensation Amount (S\$)

Have you made any claims against any the above insurers with respect to this injury? Yes No

5. Bank Details

Please provide your bank details below for reimbursement directly into your local bank account.

Bank Account Holder Name	Bank Name	Branch Code	Bank Account No.

6. Declaration

I declare that all the particulars given by me in this form are true and correct.

I agree that my claim may be reduced or denied and the Policy may be cancelled if I have made or were to make any false or fraudulent statements, or have withheld material facts in respect of this claim.

I also consent to DirectAsia.com obtaining information from hospitals, physicians and any other person I have consulted and I hereby authorize the giving of such information. I also agree to execute all necessary authorizations or documents for the release of such information to DirectAsia.com. A photocopy of this authorization shall be considered as effective and valid as the original.

Name

Signature

NRIC/Passport Number

Date

Medical Report

This report is to be completed by the Attending Physician. Dates should be in DD/MM/YYYY format.

Section A	
1) Name of patient (as in NRIC/Passport): <i>Mr/Miss/Mrs/Mdm/Dr*</i>	2) NRIC/Passport number:
3) When did you first attend to the patient for this condition and what was the nature of treatment?	4) When was the approximate date of discovery of the illness/injury?
5) Did the patient have any symptoms prior to consulting you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state the symptoms and when it first started:	6) If this condition existed before symptoms were apparent to the patient, when did this condition first develop?
7) What is the cause of the illness/injury?	8) What is the final diagnosis of illness or extent of injury?
9) Please state the surgical procedures/treatment and the dates rendered. If no surgery was performed, please state treatment/medication given. <u>Admission/Discharge/Surgery Date</u> <u>Surgical Procedure</u> <u>Name of Physician/Surgeon/Anaesthetist</u>	
10) Was the patient referred by any doctor to see you? <input type="checkbox"/> Yes <input type="checkbox"/> No Please state the name and address of the referring doctor:	
11) Has the patient previously consulted other doctors for the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Please state the name and address of all the other doctors: <u>Name</u> <u>First Consultation Date</u> <u>Name of Clinic & Address</u>	
Section B (To be completed only if the injury has resulted or is likely to result in disablement.)	
12) Is the injury likely to cause loss of use of the part(s) injured? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify: a) The affected part b) If the loss is related to finger/toe injuries, please state the affected phalanx and on which finger/toe.	
13) What is the percentage of disablement sustained?	14) Does the patient require follow-up treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
15) How long has the patient been disabled from engaging in or attending to usual business as the sole result of the injuries? From _____ to _____	
16) How much longer do you foresee that such disablement will continue? From _____ to _____	
17) Is the patient's disablement associated, contributed, or affected by any past illness, injury or accident? If so, please give details:	
Section C	
I certify that I have personally examined and treated this patient and that the answers are true to the best of my knowledge and belief, and no material fact has been concealed from DirectAsia.com.	
Name & Designation:	Signature :
Date:	Clinic/Hospital Stamp & Address :