

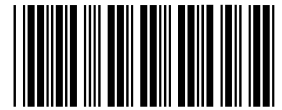


ace insurance

ACE Insurance Limited
Co Regn No: 199702449H
600 North Bridge Road
#04-02 Parkview Square
Singapore 188778

65-6398 8000 *main*
65-6298 1055 *fax*
www.aceinsurance.com.sg

PERSONAL ACCIDENT CLAIM FORM



SG009

The issue and acceptance of this form does NOT constitute an admission of liability by the Company or waiver of its rights.

SECTION A: PARTICULARS OF POLICYHOLDER / INSURED PERSON AND CLAIMANT

Name & Address of Policyholder/Insured Person:	Policy No.:	Period of Insurance:
	NRIC No.: Date of Birth: Age: Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Occupation: Date of Employment:	Tel. No. (Office): Tel. No. (Residence): E-mail Address: Name of Intermediary (if any):
Name & Address of Claimant: (If different from Insured Person)	NRIC No.: Date of Birth: Age: Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Tel. No. (Office): Tel. No. (Residence): E-mail Address: Occupation: Date of Employment:

SECTION B: DETAILS OF THE ACCIDENT

Chronology Events of the Accident:	Country of Accident: <input type="checkbox"/> Singapore <input type="checkbox"/> Malaysia <input type="checkbox"/> Others: _____	
	Place of Accident:	
	Date of Accident:	Time of Accident:
	When and Who discovered the Accident:	Relationship:
	Name & Address of any witnesses of the Accident:	NRIC/Passport No.: Contact No.:

SECTION C: NATURE OF INJURY

1. Describe in details the injuries sustained, indicating the Part of the Body injured and the type of injury (eg. Fracture, Cut, Bruise, etc.)	
2. Name and Address of Doctor(s) who treated you and Consultation Date(s).	
3. Name and Address of your usual Family Physician.	
4. Details of Hospitalization (Please attach Inpatient Discharge Summary & Original Final Hospital Bill): (a) Name of Hospital: _____ (b) Period of Hospitalization: Date Admitted: _____ Date Discharged: _____	
5. Details of Temporary Disability from engaging in or attending to your usual business as a result of the injuries. (a) Light Duties: Date from _____ to _____ (b) Medical Leave: Date from _____ to _____	
6. Date returned/expected to return to work.	

SECTION D: ANY OTHER INSURANCES

Are you claiming from any other insurance company or other insurance company or other sources in respect of this injury? If **yes**, state:

<u>Name of Insurance Company</u>	<u>Policy No.</u>	<u>Amount of Benefits</u>	<u>Date Insurance Effected</u>

DECLARATION AND AUTHORIZATION

- 1) I/We declare that the above information is true and complete to the best of my knowledge and belief.
- 2) I/We hereby authorize any doctor or any other person who has ever medically attended to the Insured Person, or any Hospital in which he or she has been treated to disclose any relevant knowledge or information which they acquired, to ACE Insurance Limited or their Authorized Representative.
- 3) I/We hereby request and authorize ACE Insurance Limited to pay benefit due in respect of this claim to: _____
(other than Insured)

Insured Person's signature: _____ Date: _____ Insured's signature: _____ Date: _____

Note: If (a) The Insured is claiming on his own belief or (b) the Insured Person concerned is a Child under 18 years of age – only the Insured 's signature is required.

ATTENDING PHYSICIAN'S STATEMENT (TO BE COMPLETED BY ATTENDING PHYSICIAN)

Name of Patient:	NRIC No.:	Date of Birth:
1. Date on which you first saw the patient.		
2. Is condition due to injury or Sickness?	<input type="checkbox"/> Sickness <input type="checkbox"/> Accident on _____ (DD/MM/YY)	
3. Was the patient referred to you by another doctor? If so, please furnish Name and Address of referral doctor.		
4. (a) Of what symptoms did the patient complain? (b) According to the patient, how long had he/she been experiencing these symptoms?	(a) (b)	
5. In your opinion, how long do you feel the symptoms had lasted?		
6. Had the patient previously seen any other doctor or receive treatment on account of these symptoms? If so, please give details.		
7. (a) What was your final diagnosis? (b) Does injury results in fracture of bones? If yes, which part of the body?	(a) (b) <input type="checkbox"/> No <input type="checkbox"/> Yes - <input type="checkbox"/> Simple Fracture <input type="checkbox"/> Compound Fracture	
8. Did Injury or Sickness require: (a) Hospitalization? (b) X-rays? (c) Special diagnostic procedure? (d) Surgery?	(a) <input type="checkbox"/> No <input type="checkbox"/> Yes Date Admitted: _____ Date Discharged: _____ (b) <input type="checkbox"/> No <input type="checkbox"/> Yes (c) <input type="checkbox"/> No <input type="checkbox"/> Yes (d) <input type="checkbox"/> No <input type="checkbox"/> Yes Type of Surgery: _____ _____	
9. Is patient still under your care for this condition?	(a) <input type="checkbox"/> No <input type="checkbox"/> Yes	
10. Bearing in mind the patient's occupation as stated overleaf, do you feel that the injuries or sickness would have prevented him from working?		
11. How long was or will patient be continuously totally disabled (unable to work)?		
12. How long was or will patient be partially disabled?		
13. Give details of any circumstances, such as intoxication, 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 : _____