Claim Form

ERGO
To insure is to understand.

ERGO AccidentProtect Group

The issue and acceptance of this form and its accompanying documents (if any) does NOT constitute an admission by ERGO Insurance Pte. Ltd. that any part or the whole of the Claimant's claim is accepted. It also does not constitute a waiver of ERGO's rights in accordance with the terms and conditions of the Policy. Any documentary proof or report required by the Company shall be furnished at the expense of the Policyholder or Claimant.

This form must be completed truthfully and accurately, please answer in full all applicable questions. The list of documents required is not exhaustive and we reserve our right to request from you any additional information/ supporting documentation, as necessary. The submission of an incomplete form or insufficient information or supporting documents may delay the claims processing or result in the denial of your claim.

The completed form should be returned together with all supporting documents as soon as possible to the following address:
ERGO Insurance Pte. Ltd.
8 Temasek Boulevard
#04-01Suntec Tower Three
Singapore 038988

Policy No.		Product Name and Plan	

Part I: Particulars of Policyholder

Policyholder's Full Name					
Date of Birth	DD / MM / YYYY		NRIC/FIN		
Contact Details	(M)		(O)		(R)
Occupation			Nature of Business		
Preferred Mode of Communication	☐ Postal Mail ☐ E-Mail	E-mail Address			

Particulars of Claimant (☐ Same as policyholder)

Insured Person's Full Name	☐ Mr ☐ Mrs ☐ Ms				
Date of Birth	DD / MM / YYYY	NRIC/FIN		Gender	☐ Male ☐ Female
If claimant is not the policyholder, state relationship to policyholder					
Contact Details	(M)		(O)		
Occupation		Nature of Business			
Preferred Mode of Communication	☐ Postal Mail ☐ E-Mail	E-mail Address			

Preferred Correspondence Address	

Preferred Mode of Claim Payment ☐ Electronic transfer ☐ Cheque

Bank Account Details (for direct transfer to your bank account)

Name (as per bank account)			
Bank Name		Bank Code	
Account No.		Branch Code	
Cheque made payable to			

Part II: Accident & Injury Details

Type of Disablement Claim	☐ Permanent Total Disablement ☐ Permanent Partial Disablement ☐ Weekly Benefit for Temporary Total Disablement ☐ Accident Medical Reimbursement ☐ Others (please specify): _____
The nature of your claim (If the claim is in respect of accidental death)	☐ Death Benefits ☐ Disappearance ☐ Family Allowance ☐ Compassionate Death Allowance ☐ Others (please specify): _____
Date and Time of Accident	DD / MM / YYYY HH : MM ☐ AM ☐ PM — Location of Accident
Description of Accident	
Description of Injury Sustained (e.g. body part injured, injury type)	

If you had a history of similar injury, which you have experienced in the past, please give details as to when, where and from whom you received medical diagnosis, treatment, consultation or prescribed drugs

Were you in good health and free from physical defect or infirmity at the time of the accident?			
Disablement Commencement	DD / MM / YYYY HH : MM ☐ AM ☐ PM	Date of Death	DD / MM / YYYY
Are you still suffering the above stated disability?	☐ Yes — Expected date & time of returning to work: DD / MM / YYYY HH : MM ☐ AM ☐ PM ☐ No — Date & time of returning to work: DD / MM / YYYY HH : MM ☐ AM ☐ PM		
Have you sustained any fractures from this accident?	☐ Yes ☐ No If yes, please advise the type of fracture: _____		
Have you sustained a burn injury from this accident?	☐ Yes ☐ No If yes, please provide the following information: ☐ Head ☐ Body Degree of burn: _____		
Have you filed a police report	☐ Yes ☐ No	Date of report: DD / MM / YYYY	Police Station in which you filed the report

Were there witnesses to the incident?	☐ Yes ☐ No	If Yes, please provide details below
	Witness 1	Witness 2
Name		
Address		
NRIC/FIN		
Contact Number		
Was the sum insured or benefits of your policy based on your monthly salary?	☐ Yes ☐ No If yes, please advise the last drawn salary prior to the accident: _____	

Please furnish the details of any hospitalization in connection with this injury

Name of Hospital	Admission No.	Admission Date	Date Discharged	Type of Ward
		DD / MM / YYYY	DD / MM / YYYY	
		DD / MM / YYYY	DD / MM / YYYY	

Please furnish information on your first consultation

Doctor Consulted			
Doctor's Address			
Doctor's Contact No.		Doctor's File Ref No. (if applicable)	

Please furnish information of your regular doctor

Family Doctor			
Family Doctor's Address			
Family/ Regular Doctor's Contact No.		Doctor's File Ref No. (if applicable)	

Part III: Others

In respect of any other claim, which does not fall within the sections stated above, please provide details of the claim you are submitting. If the space is insufficient for such details, please attach another page:

Date & Time of Accident	DD / MM / YYYY HH : MM	☐ AM ☐ PM		Claimed Amount	
Have you filed a police report	☐ Yes ☐ No	Date of report	DD / MM / YYYY	Police Station in which you filed the report	

Part IV: Details of Your Other Insurance or Compensation Claims

Have you made a claim against any other party in respect of this event? If yes, please provide:

Name of Insurance Company/Other Party	Policy/Reference No.	Type of Benefit	Have you filed a claim?	Amount claimed

If the space provided is insufficient for your answer, please continue on a separate sheet.

Have your other claims been paid by the other policies above? ☐ Yes ☐ No

Part V: For Company/Organisation use only

Declaration by Company/Organisation:

I/ We hereby certify that _____ is/my our employee effective from _____ and is currently holding the position of _____

If no longer under employment, please advise the last date of employment: DD / MM / YYYY

Name/Designation		
Date Signed	DD / MM / YYYY	Authorised signature of Business/Organisation (Please also affix Business/Organisation stamp)

Acknowledgement and Declaration

[***Declaration***] I/we declare that the particulars stated above are true, accurate and complete and I understand that if I have in this or in any further declaration in respect of this claim, made any false or fraudulent statement or suppress conceal or falsely state any material fact whatsoever my claim may be refused.

[***Authorization***] Where applicable, I/we hereby authorize any hospital, clinic, physician or any other person to disclose all information including copies of all hospital or medical records on the patient when requested by ERGO Insurance Pte. Ltd. (ERGO). I have noted that any illness, injury, consultations, medical history, prescriptions or treatment the medical report fee incurred will be borne by me. A copy of this authorization shall be considered as effective and valid as the original.

[***Personal Data Protection Statement***] I/we understand, acknowledge, agree and consent that:

a. ERGO Insurance Pte. Ltd. (ERGO) may/will collect, use, disclose and/or process my/our personal data set out in this form and any other information provided by me or possessed by ERGO for the purpose of enabling ERGO to provide me with services required of an insurance provider, such as evaluating, processing, administering, and/or managing of my relationship and policies with ERGO. This includes among other things policy servicing, processing, investigating, handling, administering and/or settling my/our claim with ERGO or other insurers;

b. ERGO may/will disclose and transfer my/our personal data to third parties, including but not limited to its affiliates, representatives, agents and thirdparty service providers, lawyers/law firms, whether located within or outside Singapore, for one or more of the above purposes, and the said third parties may/will subsequently collect, use, disclose and/or process my/our personal data for or more of the above purposes;

c. The personal data protection clauses herein are not exhaustive. I/we have read, understood and accept the terms of ERGO's Personal Data Protection Policy at http://www.ergo.com.sg/pdpa;

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If I/we provide personal data of a third party (e.g. information of insured persons, beneficiaries, beneficial owners, dependents, customers, payees and/or employees) to ERGO, I/we represent and warrant to ERGO that prior consents have been obtained from each of the third parties to provide such information.

Signature of Claimant		Date Signed	DD / MM / YYYY
Signature of Policyholder		Date Signed	DD / MM / YYYY
Name		Company Stamp	
Designation			

Intermediary Information (if applicable)

Intermediary Code		Branch	
Intermediary Name			
Contact Person		Contact No.	
Postal Address			
Preferred Mode of Communication	☐ Postal Mail ☐ E-Mail	E-mail Address	

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