CHUBB®

Work Injury Compensation
Claim Form (for Platform Operators and Workers)

Important Information:
The information requested and documents mentioned in this form are a general guide. Further documents or information may be required depending on the circumstances of your claim. Note that failure to provide supporting documentation may result in delays in the processing of your claim. Your Policy may not provide cover under every section shown in this Claim Form. The issuance and acceptance of this form does NOT constitute an admission of liability by Chubb Insurance Singapore Limited (Chubb) or waiver of its rights.

Instructions:
Please download/save this claim form to enter your claim details. Kindly submit the completed claim form via one of the following options:

- By email: WICA-PWClaims.SG@Chubb.com (**Recommended**); or
- Contact your broker/agent.

When submitting your claim, please include copies of the relevant supporting documents. For more information, contact us

- O +65 6398 8785; or
- Visit our website at www.chubb.com/sg

Important Note: Please ensure that you retain the original medical receipts/hospital bills/medical certificates for 3 years. We reserve the rights to request for sight of the original documents on a need-be basis.

Section A: Particulars of Platform Operator and Platform Worker

Name of Platform Operator

Policy No.

Period of Insurance From To

Name of Injured Platform Worker

Address of Injured Platform Worker

NRIC/Passport No. Nationality

Date of Birth Age

Tel No. (Mobile) Gender ☐ Male ☐ Female

Email Address Date of Employment

Do you work for more than one Platform Operator? ☐ Yes ☐ No

If Yes, how many Platform Operators did you work with for the same service in the last 90 days prior to accident?

Please provide details of the other Platform Operators.

Was the Injured Platform Worker free from any physical defect or infirmity at the time of accident? ☐ Yes ☐ No

If No, please furnish with details.

Would such physical defect or infirmity have contributed towards this accident? ☐ Yes ☐ No

If Yes, please furnish with details.

Section B: Payment Details

Please provide details for payment of your claim in the event that the claim is deemed payable by Chubb.

I hereby authorise and request Chubb to pay benefit due in respect of this claim as follows:

☐ **Electronic Funds Transfer** (For payments in SGD and to bank accounts in Singapore)

Payee Name (As per bank account name):

Name of Bank:

Branch Code Number: Account Number:

Note: For a more seamless experience, we recommend selecting the Electronic Funds Transfer (EFT) option so you can receive the remittance within 3-5 days upon approval of claim.

Important Notice:
Chubb shall (i) be discharged from all liability under this claim and (ii) not be liable for any and all losses incurred by you, as a result of you providing Chubb with an incorrect bank account number under this section for the payment of this claim.

Section C: Details of Accident

Date of the Accident

Time of the Accident (24-hr)

Country of Accident

Place of Accident

Describe in detail how the Accident occurred (Please use supplementary sheet if necessary and also state the type of machinery involved, if any)

When did you receive news of the Accident

Were there witnesses to the incident?

If Yes, please provide details below:

	Witness 1	Witness 2
Name		
Address		
NRIC		
Contact Number		

Describe the nature of the work or contract going on at the material time.

Are you satisfied that the Injured Worker has met with a bonafide accident of employment? ☐ Yes ☐ No

If No, please state reason(s):

Did this accident occur as a result of another person's negligence? ☐ Yes ☐ No

If Yes, please provide details of Negligent party:

Was the Injured Worker guilty of any misconduct/disobedience to orders/rules? ☐ Yes ☐ No

If Yes, please state the misconduct:

Was the Injured Worker under the influence of drink or drugs at the material time? ☐ Yes ☐ No

If Yes, please specify:

Has the Injured Worker met with any previous accident under your employment? ☐ Yes ☐ No

If Yes, please furnish details:

Has this accident been reported to the Ministry of Manpower? ☐ Yes ☐ No

If Yes, please attach a copy of I-REPORT.

Please state the date that the Injured Worker returned to work

Section D: Nature of Injury

Describe in detail the injuries sustained, indicating the Part(s) of body injured and its type of injury (E.g. Fracture, Cut, Bruise, etc).
(Please use supplementary sheet if necessary)

Has the Injured Worker ever had this or any similar condition or injury? ☐ Yes ☐ No

If Yes, please furnish details:

Please state all medical condition(s) or previous injury sustained by the worker and also indicate which are the injuries that arose out of Work Injury accidents. (Please use supplementary sheet if necessary)

Date of first treatment sought

Name of Hospital/Clinic

Address of Hospital/Clinic

Period of Hospitalisation

Period of Medical Leave From To

Section E: Detailed Earnings of The Injured Platform Worker

Please provide detailed gross monthly earnings of the Injured Worker for the last 90 days prior to accident:

Dates	Gross Earnings	Mode of Transport
Total Earnings		

Section F: Declaration

Did you remember to enclose the following? (Where applicable)

Document	Yes	N/A
Copy of iReport submitted to Ministry of Manpower	☐	☐
Medical Bills and Medical Certificates	☐	☐
Proof showing Platform Worker is performing a job at time of accident	☐	☐
Proof of earnings for the last 90 days prior to the accident	☐	☐
Written notes from Physician on type of injury sustained/Inpatient Discharge Summary or Medical Report	☐	☐
Copy of Death Certificate, Post Mortem Report, Autopsy Report, Police Reports, Letter of Administration (if involved fatalities)	☐	☐

By signing this form, I/We agree that Chubb will use the information supplied here and during the formation and performance of the policy, for policy administration, customer services, claims handling and fraud analysis and prevention, and that Chubb may disclose such information to its service providers, agents, authorities and other parties for these purposes.

I/We hereby authorise any hospital, physician, and any other person or entity who has attended to or examined the injured party, to furnish to Chubb or its authorised representatives, any and all information with respect to any illness or injury or loss, medical history, consultation, prescriptions or treatment, copies of all hospital, medical or other records, investigation status and results, and such personal information as Chubb in its absolute discretion considers relevant for its assessment of this claim. A photostatic copy of this authorisation shall be considered as effective and valid as the original.

I/We do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I/We agree that if I/We have made or in any further declaration or representation shall make any false or fraudulent statements or suppress, conceal or falsely state any fact whatsoever the Policy shall be void and all rights to recover thereunder in respect of past, present or future claims shall be forfeited.

Name and Designation of Authorised Person

Signature with Company Stamp

Date (DD/MM/YYYY)

Name of Injured Platform Worker

Signature of Injured Platform Worker

Date (DD/MM/YYYY)

NRIC/Passport No./Work Permit No. of Injured Platform Worker

Please click on the button to submit your claim form

Submit

Chubb. Insured.™