GREAT AMERICAN INSURANCE COMPANY

UEN: T15FC0029B
Reg No: M90370081T
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Personal Accident Claim Form

IMPORTANT NOTICE

The acceptance of this form is not an admission of liability. It should be completed as fully and accurately as possible and returned immediately. If the claim is found to be fraudulent, or if any fraudulent means are used to obtain any benefit under this policy, the policy will be rendered void.

1. Particulars of Insured

Name of Insured: _____	NRIC / Passport No.: _____
Policy No.: _____	Contact Person / Telephone No.: _____

Post Address: _____

2. Answer is required to each of the following questions

1. State the nature of the occurrence and date on which it has taken place.	Nature of occurrence: _____ Date of occurrence: _____ Time of occurrence: _____
2. State the place at which the occurrence had taken place (address).	_____ _____
3. Describe the full circumstance of the accident.	_____ _____
4. Describe the injury you have sustained (e.g. body part injured, injury type).	_____ _____
5. Have you had a similar injury before this incident? (If so, please specify the date and condition.)	_____ _____
6. Are you claiming, or entitled to a claim for this accident from any other insurance company or society? (If so, please provide the details.)	_____ _____
7. Please provide name and contact details of the witness of this accident (if any).	_____ _____
8. Please provide the name and address of the doctor who has attended to you.	_____ _____
9. Please advise if the attending doctor is the doctor whom you usually consult.	_____ _____
10. Has the attending doctor attended to you during the past ten years for any illness or injury? (If the answer is yes, please provide details of the illness or injury and treatment).	_____ _____ _____
11. Have you, as the direct result of the accident, been totally incapacitated from attending to business or occupation of any kind? If the answer is yes, please indicate the duration of such incapacitation.	_____ _____ _____

12. Are you still incapable of attending to business or occupation of any kind?	
13. If you are now able to attend to any portion of your business or occupation, please indicate the date you have commenced to do so.	
14. Have you now fully resumed your usual business or occupation? (If so, please indicate the date.)	
15. Please indicate a date and time on which you may be visited by a representative of the Insurance Company.	

Required Documents

- Medical Certificates
- Original Final Hospital / Medical Bills
- Medical Reports / Inpatient Discharge Summary (if any)
- Police Report / Accident Report (for traffic accident claim, etc)
- Death Certificate – (for death claim only)

I declare that to the best of my knowledge and belief that the above particulars are true and accurate. If I made or shall make any false or fraudulent statements, or withhold material facts whatsoever in respect of this claim, the policy shall be void and I shall forfeit all rights to the benefit therein. I authorise any hospital doctor, other person who has attended to or examined me, to provide to the Insurance Company, and/or its authorised representatives, with any and all information relating to my medical conditions, illness, injury, medical history, consultation, prescription or treatment and copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original. I further declare that the information provided in this claim form or held by Great American Insurance Company, Singapore Branch whether contained in my / our insurance application or otherwise obtained may be used and disclosed to your employee, authorised representative and/or companies or any independent third parties (within or outside Singapore) who will provide claims administrative, advice and/or information of claims services in relation to my / our claim. I / We understand that my / our data may also be used for the purpose of audit, business analysis and reinsurance. My / Our signature provided hereunder shall signify this consent.

Date_____ **Signature of Insured (with Company Stamp if applicable)** _____

Designation: _____ **Name:** _____ **NRIC / Passport No.:** _____