GREAT AMERICAN INSURANCE COMPANY

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Work Injury Compensation Claim Form

IMPORTANT NOTICE

1. This form is to be furnished by the employer.
2. The acceptance of this form is not an admission of liability. It must be completed as fully and accurately as possible and returned by e-mail or post immediately.

The Employer

1. Name of Insured _____

	Yes	No
2. Are you GST registered at the commencement of insurance?	☐	☐

3. Postal Address _____
4. Email Address _____
5. Policy No. _____

The Insured Person

6. Name _____
7. Nationality _____ Age _____ Gender _____
8. Identity Card No. / Work Permit No. _____ Tel No. _____
9. Local residential address _____
10. State occupation in which the injured person is employed _____
11. Number of working days per week _____

	Yes	No
12. Was the injured person engaged in this occupation when the accident occurred?	☐	☐

If no, provide details of what the injured person was doing at the time of accident. _____

13. Is the injured person in your direct employment?	☐	☐

If no, provide name and address of Contractor and their Insurers *(Attach Contract Agreement)* _____

14. When did the injured person enter your service? _____

15. Has the injured person ever received compensation for a previous disability?	☐	☐

If yes, provide details. _____

16. Did the injured person suffer from any physical ailment(s) prior to the accident?	☐	☐

17. Name of hospital the injured person was taken to:
    a. In or Out-Patient _____
    b. State whether injured person is still in hospital, or date of discharge _____

18. Has the injured person been medically examined?	☐	☐

If yes, please send report.
If no, please explain. _____

19. State whether the injured person has returned to work, and **if yes**, when was it? _____

20. Are you satisfied that the injured person has met with a bonafide accident at work?	☐	☐
21. Is the injured person able to perform partial work?	☐	☐

22. What is the probable period of disablement *(approximate)*? _____

The Accident

23. Date, Time & Place _____

24. When did you receive notice of accident and from whom? _____
If it was received in writing, please attach it to this form.

25. On what date did the injured person actually cease work? _____

26. Brief description of the accident _____

_____

27. If the accident was due to machinery or gearing, please state:	Yes	No
a. Whether it was fenced or guarded? _____		
b. Was it being cleaned whilst set in motion?	☐	☐
c. Did the workman receive proper training:		
i. In the job he was performing at the time of accident?	☐	☐
ii. In the use of the machine which had caused the injury?	☐	☐

State the period during which he received the training _____

28. List names and contact details of persons who witnessed the accident. _____

_____

29. Was the injured person under the influence of alcohol or drugs at the time of accident?	☐	☐
30. Was the person guilty of any misconduct or disobedience to orders or rules?	☐	☐

If yes, please give full particulars. _____

_____

31. State whose negligence, (if any) had led to the accident _____

_____

32. State clearly the injured part(s) of the body _____

33. State the date on which the accident was reported to the Commissioner of Workplace Safety & Health *(Attach i-report)*

_____

_____

34. If accident was reported to the police, please state the date *(Attach Police Report)* _____

ADDITIONAL PARTICULARS FOR FATAL CASES ONLY

Please furnish:

1. Date of Inquest, if any.
2. Post Mortem Report
3. Death Certificate
4. Police Report

The Accident *Continued*

Give details of workman's earnings for the period of 12 month preceding the accident.

[Note – The object of this form is to ascertain the exact monthly earnings of the injured person. It is essential that it should be carefully and correctly completed. If the injured person has been absent from work at any time during the period of his employment, please state the period and the cause.]

MONTH	WAGES		BONUS, VALUE OF FREE QUARTERS & ANY OTHER ALLOWANCES, (Excluding Transport Allowances)	
	SGD ($)	SGD (¢)	SGD ($)	SGD (¢)
TOTAL				
	Total including all allowances			
	Average Monthly Earning			

Important Notice

- The injured employee is required to inform his or her employer of the accident as well as medical treatment as soon as possible. All medical fees and expenses should be paid by the employer.
- The employer is required to report the accident to the Commissioner of Workplace Safety and Health through the iReport System within the following reporting timeline, as well as notify his insurer(s), if any.

What to report	Reporting timeline
When the accident results in death of an employee	Within 10 days of occurrence
When the accident results in any incapacity that renders the employee unfit for work for more than 3 consecutive days, or is admitted in a hospital for at least 24 hours for observation or treatment	Within 10 days of occurrence
When an employee suffers an occupational disease at a workplace, and the employer receives a written diagnosis from the medical practitioner	Within 10 days from the receipt of the written diagnosis

NOTE: Failure to report a work related accident may prejudice your claim for indemnity under the policy and is also an offence which carries a fine and/or jail term

The above replies are correct to the best of my knowledge and belief.

Dated,_____ 20_____

_____

Authorised Signature & Company's Stamp
Name of Authorised Person
Designation