

WORK INJURY COMPENSATION CLAIM FORM

The issue of this form is not an admission of liability. It should be completed as fully and accurately as possible and returned **immediately** together with a copy of the Ministry of Manpower i-Report.

Employer's Particulars

Name of Insured _____

Address _____

Name of Sub-Contractor _____

Address _____

Tel. And Fax Numbers _____

Policy No: _____ Total Number of Employees: _____ Agency: _____

Are you (**ie. Direct Employer**) covered under any other Work Injury Compensation Policy? Yes / No
(delete where applicable)

If "Yes", please state name of Insurance Company and Policy Number. _____
and provide full set of WIC Policy showing the policy terms and conditions

Injured Person's Particulars

Name: _____ IC NO./Work Permit No: _____ Sex: _____ Age: _____

Marital Status: _____ Address: _____

Nationality: _____ Occupation: _____ No. of days worked per week: _____

Is the injured person in your direct employ?
If not, give name and address of employer. _____

When was the injured person employed by you? _____

Is the injured person in receipt of Workmen's Compensation for a previous incapacity? _____

Was injured person treated as In or Outpatient? *In/Out Patient (Please delete accordingly)*

If in-patient, state name of hospital and date of discharge. _____

State when injured person returned to work. _____

Is the injured person able to do partial work? _____

What is the estimated period of incapacity? _____

