

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 Form A.

Employer's Particulars

Name of Insured _____

Address _____

Tel. and Fax numbers _____

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

Are you covered under any other
Work Injury Compensation Policy? No / Yes (Please delete accordingly)

If "Yes", please state name of Insurance Company and Policy Number _____

Injured Person's Particular's

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 Work Injury
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

Has injured person been medically examined?
If so, please send Medical Report. _____

State when injured person returned to work. _____

Is the injured person able to do partial work? _____

What is the estimated period of incapacity? _____

