MS FirstCapital

M S First Capital Insurance Limited (Co.Reg. No. 195000106C)
6 Raffles Quay #21-00 Singapore 048580
Tel: (65) 6222 2311 Fax: (65) 6222 3547

Claims & Motor Underwriting Dept: 36 Robinson Road #16-01 City House Singapore 068877
Tel: (65) 6507 3848 Fax: (65) 6507 3849
www.msfirstcapital.com.sg

Personal Accident Claim Form

This form is issued without admission of liability, and must be completed and returned within seven days after its receipt. No claim can be admitted unless a medical report be furnished at the expense of the Claimant.

1. PARTICULARS OF POLICYHOLDER	
Policy No.	Present Business or Occupation (If more than one, please state all)
Name (As per NRIC/Passport)	NRIC/Passport No.
Gender	Age
Address (Residential)	Contact Details (i.e. Telephone & Email)
Address (Business)	Contact Details (i.e. Telephone & Email)

2. DESCRIPTION OF ACCIDENT
When did accident occur? Please indicate which day, date, and hour
Where (Location of Accident) did it occur?
Give full particulars of the cause of accident , and the injuries sustained
Give details on injury(s) sustained and whether if there are previous similar injury(s)?

3. WITNESS
Give names and addresses of any Witnesses of the accident

4. MEDICAL TREATMENT
Provide Name and Address of the Doctor who attended to you for this accident
Provide Name and Address of your usual Doctor
State Where and When a Medical and/or Handling Officer of the Insurer can visit you, if necessary

5. PERIOD OF DISABLEMENT	
What is the probable/estimated period of disablement?	
Whether you have been totally unable to attend to any portion of your work/business? [ ] Yes [ ] No If so, please give dates.	From :________________To ________________ (dd/mm/yyyy)

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Whether you are still totally unable to attend to any of your business	[ ] Yes [ ] No
On what dates you were able to attend:- • To a portion of your usual business or occupation	From :________________To ________________ (dd/mm/yyyy)
• To the whole of your usual business or occupation	From :________________To ________________ (dd/mm/yyyy)

6. OTHER COMPENSATION/INSURANCE POLICY

Please state whether in respect of the accident you are entitled to receive compensation from any other source.
If so, from what source and to what extent?

Are you insured elsewhere?	[ ] Yes [ ] No

If so, Please state full particulars of the name of each Company or Insurer, and amount you are entitled to Claim.

7. DECLARATION & AUTHORISATION TO RELEASE INFORMATION

I/ We declare that the above information for the injury(s) above described, and warrant the truth of the foregoing particulars in every respect and I agree that if I have made, or if I shall make, any false or untrue statement, suppression or concealment, my right to compensation shall be absolutely forfeited.

I / We hereby acknowledge, consent and agree that:-

- MS First Capital Insurance Limited (MSFC) may collect, use and disclose all personal data provided or as may be provided by me / us and through other sources as MSFC deem relevant for the purposes as contemplated in this form including but not limited to policy servicing, processing, investigating, handling, administering and/or settling my / our claim with MSFC or other insurers;
- MSFC may disclose the personal data to the third parties (whether in or outside Singapore) in carrying out the above purposes;
- The personal data protection clauses herein ("DPC") are not exhaustive. By signing this form, I / we declare that I / we have read, understood and agreed to be bound by the prevailing Personal Data Protection Act 2012 as supplement to the DPC. If any inconsistencies between the DPC and the Data Protection Act 2012, the latter shall prevail;
- If I / we provide third parties' personal data (e.g. information of the life assureds, insured persons, beneficiaries, beneficial owners, dependents, spouse, children, parents, siblings, customers, prospects, payees and/or employees) to MSFC, I / we represent and warrant to MSFC that prior consents have been obtained from each of the third parties for the collection, usage, disclosure and processing of their personal data in the manner as set out above and the Data Protection Act 2012; and
- I / We shall indemnify MSFC for all losses and damages which may be suffered by MSFC arising out of the breach of the declarations, representations and/or warranties herein.
- I / We authorise any physician or other person who has attended to me (Claimant) to release any information acquired in the course of my examination or treatment to MSFC.

Signature of Policyholder/Insured	Date

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PRIVATE & CONFIDENTIAL - MEDICAL REPORT

IMPORTANT NOTE:-
This form is to be completed by the Claimant's Medical Doctor, whose replies should be as full as possible.
TEMPORARY TOTAL DISABLEMENT occurs when the Insured is wholly prevented from attending to his business or occupation.
TEMPORARY PARTIAL DISABLEMENT occurs when the Insured is prevented from attending to a substantial portion thereof.

No.	Question	
1.	Claimant's Name as per NRIC/Passport	
2.	The nature and extend or injury (s), If to a limb, please state whether right or left)	
3.	The cause of the accident, so far as known to you	
4.	Date of your first attendance upon claimant in consequence of the injury(s) sustained	
5.	Are you still the claimant's attending physician?	[ ] Yes [ ] No
6.	Are you his usual Medical Physician, if so how long have you known him, and for what have you attended to him?	[ ] Yes [ ] No Period: ______________________
7.	Is the claimant's symptom(s), due exclusively to the accident, if "No" is it traceable to disease, infirmity or any other cause? Please provide details below:-	[ ] Yes [ ] No
8.	Is the patient presently or was he at the time of the accident suffering from any illness, disease or infirmity? If "Yes", state the nature and to what extent his recovery has been or maybe retarded thereby as below:-	[ ] Yes [ ] No
9.	Have you any reason to suppose that he was under the influence of intoxicants at the time of the accident? If "Yes", please state the reason as below:-	[ ] Yes [ ] No
10	Bearing in mind the patient's occupation and the two definitions above, please state:- a) The period during which the patient has been totally and or partially disabled from attending to his usual business or occupation. b) The probable future duration of (i) Total and/or (ii) Partial disablement,	Claimant has been temporarily disabled (in dd/mm/yyyy format):- a) Totally From : ________________To ________________ Partially From : ________________To ________________ b) Totally From : ________________To ________________ Partially From : ________________To ________________
11.	Has the patient sustained any permanent disability? If so, please let us details:-	
12.	Is there any other information, professional or otherwise that you consider should be made known to us? If so, please let us have detail:-	

I hereby certify that the above-named met with the accident referred to and that the foregoing statements are correct.

Name, MCR and Signature of Attending Physician	Date and Hospital/Clinic Stamp