MS 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

WORK INJURY COMPENSATION CLAIM FORM

The issuance 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

1. INSURED'S PARTICULARS

Policy No.	
Name of Insured (Principal)	
Address	
Main Contractor (where applicable)	
Is the injured person in your direct employment? If "No", give name and address of employer below	Yes / No (Please delete where applicable)
Sub-Contractor and/or Direct Employer (when applicable)	
Address of Sub-Contractor and/or Direct Employer	
Telephone of Sub-Contractor and/or Direct Employer	
Email of Sub-Contractor and/or Direct Employer	

Total No. of Employees		Broker/Agency	
Are you (i.e. Direct Employer) covered under any other Work Injury Compensation Policy?			YES/NO (Please delete where applicable)

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

Insurance Company : _____

Policy Number : _____

2. INJURED PERSON'S PARTICULARS

Name (as in NRIC/WP/PP)		NRIC/Work Permit No.	
Nationality (for Work Permit Holder)		Occupation	
Gender		Marital Status	
No. of working days per week		Age (as at accident date)	

Notice : Please provide a copy of the employee's duty roster if the working hours/days are not fixed

When was the injured person employed by you?	(dd/mm/yyyy)
Is the injured person in receipt of WICA for a previous incapacity?	Yes / No (Please delete where applicable)

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Was injured person treated as inpatient or outpatient? (If inpatient, state hospital and date of discharge below)		In / Out Patient (Please delete where applicable)	
Hospital		Discharge Date	(dd/mm/yyyy)
Has injured person been medically examined? If "Yes", please provide Medical Report (if any)		Yes / No (Please delete where applicable)	
State when injured person returned to work			(dd/mm/yyyy)
Is the injured person able to do partial work/light duty?		Yes / No (Please delete where applicable)	
What is the estimated duration of MC (if any)			

3. DETAILS OF ACCIDENT

Date	(dd/mm/yyyy)	Time	(hh:m:ss)
Location where Accident occurred			
Complete Details of Accident			
Any eye witness(s)? If "Yes", please provide Name and contact details below		Yes / No (Please delete where applicable)	
Witness Name and Contact Details			
Has accident been reported to Ministry of Manpower? If "Yes", please provide i-Report		Yes / No (Please delete where applicable)	
Has accident being investigated by the Police or Relevant Authority? If "Yes", provide details/report		Yes / No (Please delete where applicable)	

4. ADDITIONAL INFORMATION FOR FATAL CASES ONLY

If the Deceased has any Dependants? If "Yes", please provide details as stated below	Yes / No (Please delete where applicable)
Kindly state names, addresses, gender, relationship, ages and occupations of each dependant :-	

IMPORTANT : Please provide a copy of the Police Report and inform the date of Coroner's Inquiry

5. EARNINGS OF INJURED PERSON

- The objective of this section is to ascertain the exact Average Monthly Earning (AME) of the injured person.
- State the monthly earnings for the last 12 months preceding the accident including Wage Supplement/Bonus.
- AME shall not include any transport allowance.
- If injured person is daily/hourly rate please provide the pay rate – SGD : _____

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Please complete the following table for AME calculation

No.	Month	Gross Monthly Earnings (Excluding Bonus)	Annual Wage Supplement / Bonus paid during last 12 months
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
Total of Basic Wages + Wage Supplement/Bonus for 12 months			
Average Monthly Earning (Total earnings divide by 12 months			

6. DECLARATION

I/ We declare that the above information is true and complete to the best of my/our knowledge and belief and I/we claim in respect thereof the protection of my/our policy. I / We hereby acknowledge, consent and agree that:-

I. 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;

II. MSFC may disclose the personal data to the third parties (whether in or outside Singapore) in carrying out the above purposes;

III. 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;

IV. 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

V. 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.

Principal Insured's Rep Name/ Designation & Signature	Company Stamp	Date
Main Contractor's Rep Name/ Designation & Signature	Company Stamp	Date
Direct Employer's Rep Name/ Designation & Signature	Company Stamp	Date