



Liberty Pte Limited
One Raffles Quay #40-01 North Tower
Singapore 048583
Tel: 1800-LIBERTY (5423 789)
UEN | GST Reg. No. 201538069C
libertyinternational.com/sg

Claim Form – Personal Accident

Please complete all sections to facilitate the processing of your application. This form is issued without admission of liability and it must be completed and returned to us immediately, whether or not a claim is made. Any documentary proof or report required by Liberty shall be furnished at the expense of Policyholder or Claimant. Please submit the completed and signed claim form together with supporting documents to: Claims_admin.sg@libertymutual.com.

Information of Policyholder

Name of Policyholder: _____	Policy No.: _____
Is Policyholder GST – registered?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, is Policyholder allowed to claim the GST on the Insurance Premium paid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Email: _____	Contact No.: _____
Mailing address: _____	Postal Code ()

Information of Claimant

Name of Claimant: _____	Occupation: _____
Mailing address: _____	Postal Code ()
NRIC/FIN No.: _____	Contact No.: _____
Email: _____	

Details of Accident/Injury

Date of Accident/Injury: _____	Time of Accident/Injury: _____	Place of Accident/Injury: _____
How did Accident happen? _____		
Describe the Nature of Injuries sustained? _____		



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Are there any other policies of insurance in-force covering you in respect of this event? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please state:	
Name of Insurance Company:	Policy No.:
_____	_____
Type of Policy:	Amount of Compensation:
_____	_____
Have you ever had any previous claims? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please state:	
Name of Insurance Company:	Date of Previous Claims.:
_____	_____
Circumstances:	Amount Claimed:
_____	_____
Are you making a claim for the same event from another source/policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please state:	
Claim Details:	Amount of Compensation:
_____	_____

Amount Claimed in respect of Medical Expenses

Date of Treatment	Details of Medical Expenses Incurred	Currency & Amount Paid

Please provide:

- Original medical bills and/or medical reports/memo from the attending doctor stating the nature of the injury if you are treated as an outpatient as a result of an accident
- Original hospital final bill and inpatient discharge summary/medical report if you are hospitalized as a result of an accident



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Payment Details

Please select the claim payment mode.

- For payment by direct transfer into Policyholder's bank account.

Please provide a copy of your bank account statement showing the Name of Bank, Name of Account Holder and Account Number for your initial claim submission.

Full name (as shown in the bank account): _____	Nationality: _____
Name of Bank: _____	Bank Account Number: _____

- For payment by PayNow

Please provide us with a copy of NRIC for verification purpose. The claim reimbursement can only be made to the Insured/Claimant and will be paid via transfer to your bank account linked by PayNow NRIC/FIN ID by default. Please ensure that you have signed up for PayNow with your bank by linking it to your NRIC/FIN ID.

NRIC/FIN ID: _____	UEN: _____
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INDEMNITY

The Company shall not be liable for any loss incurred by you as a result of you providing the Company with incorrect bank account details for the payment of your claim.

PERSONAL DATA PROTECTION

By signing this form, I/we consent to Liberty Pte Limited ("Liberty") and its authorised service providers, related entities, and partners (collectively, "Appointees") collecting, using, and disclosing my/our personal data, and any personal data of other individuals provided by me/us, for purposes including: assessing and providing insurance products and services; policy administration, renewals, claims, and payments; compliance, audit, and regulatory reporting; research, analytics, and service improvement; and communication and customer support. I/we confirm that I/we have read and agree to Liberty's Data Protection Policy at <https://www.libertyinternational.com/sg/footer/privacy-policy>, which explains how Liberty manages personal data, including cross-border transfers. If I/we provide personal data of other individuals, I/we warrant that I/we have obtained their consent (or consent from their legal representatives, where applicable) for these purposes. I/we understand that I/we may access, correct, or withdraw consent for my/our personal data at any time by contacting Liberty's Data Protection Officer at privacy.officer.ap@libertyglobalgroup.com, subject to legal and contractual obligations.

DECLARATION

- 1) I declare that I have complied with the conditions and warranties (if any) of the Policy and in no manner deliberately caused the said loss or damage or exaggerated the claim or sought unjustly to benefit by any fraud or willful misrepresentation and that the information shown on this Form is true and that I have not concealed any information relating to this claim. I understand Liberty reserves the right to repudiate the claim if it is later proven false or intentionally omitted by me.
- 2) I authorise the release of any medical information necessary to process this claim.

Date

Signatory of Claimant

Date

Signatory of Authorised Policyholder and
Company Stamp



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Medical Information (to be completed by the attending physician)

Name of Patient: _____		NRIC/FIN No.: _____
Date when the Patient first consulted you: _____	Is condition due to: <input type="checkbox"/> Injury <input type="checkbox"/> Sickness	
Presenting Complaints: _____		
Was the Patient referred by another physician? If Yes, please provide the referral letter		<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Physician: _____	Address: _____	Contact No.: _____
State diagnosis of the illness/injuries: _____	Date of diagnosis: _____	
Describe in detail the injuries sustained, indicating the part of the body injured and the types of injury (e.g. fracture, cut, bruise, etc.): _____		
The cause of the Accident, so far as known to you: _____		
Are you the Patient's usual Medical Attendant? If Yes, how long have you known him/her and for what reasons were the medical treatments rendered? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the Patient ever experienced any pre-existing condition/symptom at the injured area(s) stated above prior to the accident?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Nature of pre-existing condition or symptom: _____	When did the condition or symptom first start? _____	



