



**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 – Work Injury Compensation

### Document(s) for submission of claims to Liberty Pte. Limited

Document Required	Attached
1. Claim Form – (Did <u>accident</u> arise out of and in the course of employment?)	q
2. I-Report (if accident results in more than 1 day MC/hospitalisation for more than 24 hours/death)	q
3. Work Permit/Employee Pass (for foreign worker)	q
4. Copy of medical report (if available)	q
5. Inpatient Discharge Summary	q
6. Original medical bills and medical leave certificates	q
7. Copies of wage payment vouchers for 12 months prior to date of accident (e.g. accident in January 2019, require wage payment voucher for January 2018 to December 2018)	q
8. Please indicate the number of work days per week under “Earnings of Insured Worker” of the enclosed Claim Form	q
9. Contract (with value) for job accident site (where accident site is not insured premises)	q
10. Contractual agreement between main contractor and sub-contractor (for project policy)	q
11. Annual WICA policy of the other party (main/sub-con) insurer covering accident at worksite (for project policy)	q
12. Police report (where serious accident occurs resulting in fire, explosion collapse of building, etc)	q
13. Traffic police report (where it is a road traffic accident)	q
14. Death certificate and relevant reports (where accident results in death)	q
15. Timesheet/Attendance/Work Schedule for the month of accident	q
16. Copy of Toolbox Meeting (if applicable)	q

Note: Additional documents may be requested as and when necessary



## Claim Form – Work Injury Compensation

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](mailto:Claims_admin.sg@libertymutual.com).

### Information of Policyholder

Name of Policyholder: _____		Policy No.: _____								
Mailing Address: _____		Postal Code (       )								
Email: _____	Contact No.: _____									
Name of Main Contractor (if Policyholder is not the main contractor) for this project: _____		Nature of Business: _____								
Total No. of Employees: _____	Name of Insurer(s): _____	Policy No.: _____								
Is your company GST registered? If so, please confirm if you are claiming GST chargeable on the medical expenses from IRAS.		<table> <tr> <td>q</td> <td>Yes</td> <td>q</td> <td>No</td> </tr> <tr> <td>q</td> <td>Yes</td> <td>q</td> <td>No</td> </tr> </table>	q	Yes	q	No	q	Yes	q	No
q	Yes	q	No							
q	Yes	q	No							

### Details of Injured Employee

Name of the Injured Employee: _____		NRIC/FIN No. of Injured Employee: _____
Mailing Address of Injured Employee: _____		Postal Code (       )
Contact No. of Injured Employee: _____	Age of Injured Employee: _____	Citizenship of Injured Employee: _____
Marital Status of Injured Employee: _____	Gender of Injured Employee: _____	Date Entered Service of Injured Employee: _____
Occupation of Injured Employee: _____		
Was the worker engaged in the occupation when the accident occurred? If No, please provide details: _____		



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Is there any other policy(ies) covering the worker in respect of this accident? If No, please provide details:  _____		
Is the worker your direct employee? If No, please provide details of direct employer:  Name of Direct Employer: _____		Contact No. of Direct Employer: _____
Mailing Address of Direct Employer: _____		Postal Code (        )

### Details of Accident

Date of Accident: _____	Time of Accident: _____	Place of Accident: _____
Address of Accident: _____		Postal Code (        )
Date that the accident was reported to you (if in writing, attach correspondence): _____		
Was the worker injured due to his/her misconduct or failure to follow instructions? If Yes, please provide details:  _____		
Was anyone supervising the employee at the time of the accident? If Yes, please provide details:  _____		
Describe how the accident occurred:  _____		
Name of Supervisor: _____		Designation of Supervisor: _____
Mailing Address of Supervisor: _____		Postal Code (        )
Contact No. of Supervisor: _____		



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Was the accident reported to the Ministry of Manpower (MOM)? (Attach a copy of the MOM i-Report)  
If Yes, date reported:

\_\_\_\_\_

If the claim is reported too late, please provide the reason:

\_\_\_\_\_

### Responsibility/Witness (es)

Was another person, in your opinion, responsible for the accident?  
If Yes, please provide details:

Name:

NRIC/FIN No.:

\_\_\_\_\_

\_\_\_\_\_

Home Address:

\_\_\_\_\_

Postal Code (            )

Office Address:

\_\_\_\_\_

Postal Code (            )

Reason(s) why he/she was responsible:

\_\_\_\_\_

Was there a witness(es) to this event?  
If Yes, please provide details:

Name of Witness:

NRIC/FIN No. of Witness:

\_\_\_\_\_

\_\_\_\_\_

Home Address of Witness:

\_\_\_\_\_

Postal Code (            )

Office Address of Witness:

\_\_\_\_\_

Postal Code (            )

Occupation of Witness:

Contact No. of Witness:

\_\_\_\_\_

\_\_\_\_\_

### Injuries Sustained from the Accident

Details of the injuries, including the nature and region:

Date of when the worker  
ceased work:

\_\_\_\_\_

\_\_\_\_\_



## Claim Form – Work Injury Compensation

Name of Hospital/Clinic that the worker was treated: _____	Date of discharged from hospital: _____
Is the worker still undergoing medical treatment? If No, when is the worker likely to be able to return to work? _____	
Are there any more medical bills or medical leave certificate forthcoming?	

In Death cases, please furnish:

- A copy of the Death Certificate, post mortem report and police report (if any)
- List of Deceased's dependants, stating names, addresses, ages, relationships and occupations
- Date of the coroner's inquiry, if any

### Earnings of Injured Worker

The "Earnings" of an injured workman include his wages, food allowance, housing allowance, overtime, bonus or annual wage supplement but do not include travelling allowance, employer's share of the CPF contributions or pension or money paid to cover any special expenses incurred by him by nature of his employment.

No. of Working Days per Week: \_\_\_\_\_

Details: \_\_\_\_\_

Month	Gross Monthly Earning (excluding bonuses)	Annual Wage Supplement
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
Total Average	A1 S\$	A2 S\$
Total Average Earnings (A1 + A2)		



## Claim Form – Work Injury Compensation

### Payment Details

Please select the claim payment mode.

- For payment by direct transfer into Policyholder's bank account.
- For payment by direct transfer into bank account under someone other than Policyholder.  
A Letter of Authorization and/or proof of relationship is required, together with a copy of the payee's identification document (NRIC or passport) and bank statement.

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

- For payment by PayNow  
Please ensure that you have signed up for PayNow with your bank by linking it to your UEN number.

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.

### DECLARATION

- a) 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.
- b) I authorise the release of any medical information necessary to process this claim.
- c) 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 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@libertymutual.com](mailto:privacy.officer.ap@libertymutual.com), subject to legal and contractual obligations.

To enquire on the claim status, please call us at 1800-LIBERTY (5423789) or email [WICA\\_claims.sg@libertymutual.com](mailto:WICA_claims.sg@libertymutual.com).

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Claimant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Policyholder  
(Company stamp, if applicable)

