

Workplace Protect

Important Notice

This form is issued without admission of liability under the Policy. If a workplace injury occurs, you must submit this form immediately.

Each question must be answered in full. A failure to comply with this requirement may prejudice any claim you make.

You must immediately send Liberty any correspondence received from lawyers acting for the injured worker. Further, you must not, make any admission of liability whatsoever.

Claim form



1. EMPLOYER/POLICYHOLDER'S DETAILS

Policy holder

Telephone

Fax

Email

Policy number

Are there any other policies that may cover you for this accident?

Yes

No

Is your company GST registered?

Yes

No

If so, please confirm if you are claiming GST chargeable on the medical expenses from IRAS.

Yes

No

Please provide us with the Insured's banking details for the payment of medical and loss wages:

Beneficiary full name

Bank name

Swift code

Branch code

Bank code

Account no

2. INJURED WORKER'S DETAILS

Name

Gender

Male

Female

Date of birth

Citizenship

NRIC/FIN/Passport No.

Home address

If worker is a citizen or resident of the United States, is the Worker eligible for US medicare benefits?

Yes

No

3. EMPLOYMENT DETAILS

Is the injured worker your direct employee?

Yes

No

If no, please provide details of the injured worker's direct employer

What is the worker's usual occupation?

Basis of the worker's employment

Full-time

Part-time

Casual

Other

Number of days worked per week

5 days

5.5 days

6 days

Other

When did this worker first commence employment with you?

Did the worker suffer from any pre-existing injury or disability?

Yes

No

Claim form



Please list the actual monthly earnings of the worker for the 12 months preceding the accident

Month	Gross earnings excluding bonus and overtime	Additional payments/Bonus amounts received
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

4. DETAILS OF THE ACCIDENT

Date _____ Time _____ AM PM

Date the accident was reported to you _____

Where did the accident occur? _____

How did the accident occur? _____

Did any third party cause or contribute to the accident? Yes No

If yes, provide the name and contact details of the third party: _____

Was any person involved in the accident under the influence of liquor/drugs? Yes No

Was the worker injured due to misconduct or a failure to follow instructions? Yes No

Name of supervisor _____

Designation _____

Claim form



5. INJURIES SUSTAINED BY THE WORKER

Please describe the worker's injuries

Date the worker ceased work?

Is the worker still undergoing medical treatment?

Yes No

Has the worker returned to work?

Yes No

If no, please advise if the worker is on medical leave for more than 30 consecutive days.

Yes No

(If yes, please provide copy of the medical certificate)

6. DECLARATION

I/We (print name in full)

(position)

declare that the information shown on this form is true and correct to the best of my/our knowledge and belief and that I/we have not concealed any information relevant to the reported accident.

Signature and stamp of the policyholder

Date

Please attach a copy of the MOM incident report

7. RELEASE AND DISCLOSURE OF MEDICAL INFORMATION

To be completed by the injured worker.

For the purposes of this authorisation, a reference to Liberty ("Liberty") includes its service providers, representatives and agents.

- a. I authorise any hospital, doctor, clinic and other healthcare practitioner who has attended upon or examined me for any reason to:
 1. disclose to Liberty all information with respect to any injury, sickness or treatment (whether the subject of this claim or otherwise); and
 2. provide to Liberty a copy of any medical reports, hospital/clinical records arising from or associated with any such injury, sickness or treatment.
- b. I authorise Liberty to disclose my personal information (including medical reports and hospital/clinical records) to any medical practitioner, legal practitioner and any other service provider, expert or consultant for the purpose of determining and managing my claim.
- c. A photostat copy of this authorisation shall be as effective and valid as the original.

Signature of the injured worker

Date

Claim form



Privacy Notice

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