

INCIDENT REPORT FORM

ALLIANZ WORK INJURY COMPENSATION INSURANCE

THE EMPLOYER IS REQUESTED TO NOTE:

- (a) Before submitting details of the claim, the Employer is requested to read the Terms & Conditions of the Policy.
- (b) Please state all relevant information requested in this incident report form truthfully and accurately. Any documents or reports required to process this claim shall be furnished at the expense of the Employer unless specified under the Act.
- (c) This form must be filled up and delivered to the Company by email or by post together with all supporting documents immediately once a workplace injury occurs.
- (d) The Employer must promptly take all practicable steps including to lodge a police report and provide a copy of the report to the Company when required.
- (e) The Employer must inform the Company immediately upon discovery or notification of any workplace injury to the employee. All written communications received by the Employer that is related to the injury must be furnished together with this claim form.
- (f) If the claim is found to be fraudulent, or if any fraudulent means or devices are used to obtain any benefit under the policy, your claim may be declined and all benefits under your policy may be forfeited.
- (g) The issuance, submission, completion or acceptance of this form is on a without prejudice basis.

Type of Claim First Aid Only Injury With MCs Occupational Disease Observation Fatal

SECTION I : POLICY INFORMATION

Product Name: _____ | Policy No.: _____

Intermediary Name: _____ | Intermediary Code: _____

Company Name: _____

UEN: _____

Type of Business: _____

Name of Person Reporting the Workplace Injury: _____

Contact Details: (Mobile) _____ (Home) _____ (Email): _____

Designation: _____

Relationship with Injured Employee: _____

SECTION II : INJURED PERSON INFORMATION

Name of Injured Person (As per NRIC/FIN):

NRIC/FIN No:

Gender: Male Female

Claimant's Date of Birth:

(DD)

(MM)

(YYYY)

Nationality:

Contact Details: (Mobile)

(Home)

(Email)

Correspondence Address:

Occupation:

Designation:

Jobscope:

When did the injured person enter your service?

Is the injured person in your direct employment?

Yes No

If no, please provide a copy of the contract whom the injured person is.

Number of Working days per week. For shift work, please provide work schedule:

If the injured has ceased work or left employment, please provide last day of employment:

(DD)

(MM)

(YYYY)

SECTION III : OCCURRENCE INFORMATION

Date & Time of Occurrence of Incident:

(DD)

(MM)

(YYYY)

(Hours)

(Mins)

AM

PM

Incident Location:

When was the occurrence

reported to you or discovered?

(DD)

(MM)

(YYYY)

(Hours)

(Mins)

AM

PM

When was the injury first

discovered by the injured person?

(DD)

(MM)

(YYYY)

(Hours)

(Mins)

AM

PM

When was the injury reported to you?

If in writing, please attach to this form.

(DD)

(MM)

(YYYY)

(Hours)

(Mins)

AM

PM

Full particulars of circumstances surrounding the injury to the best of your knowledge or as reported to you.

What was the type of work or nature of the contract during which the injury took place?

Was the injured person under the influence of drinks, drugs or any medication at the time of the incident? Yes No
If yes, please provide details.

Was the injured person guilty of any misconduct or disobedience at the time of the incident? Yes No
If yes, please provide details.

Was the incident contributed to or caused by negligence on the part of the injured person? Yes No
If yes, in what way was the injured person negligent?

If the injury is caused by any other person in your employment or outside your employment, please provide names, address and contact information.

Police Station to which injury was reported, if any:

Date of Reporting: (DD) (MM) (YYYY)

Name of Police Station and Address:

Report No. (Please provide a copy of the police report, if any)

Was there any eye-witness? Yes No
If yes, please provide name, address, contact no. and job role in your Company.

Has this incident happened before?
If Yes, please give details and internal incident report.

Yes No

What are the steps taken by your Company to prevent a recurrence of the current incident?
Please provide details and attach a copy of your action plan.

SECTION III : INJURY INFORMATION

Name of Hospital the injured person was conveyed to:

Has the injured person ever suffer from the same/similar condition or injury?
If yes, please provide details.

Yes No

Please state nature of injury and extent of injury? Please specify whether it is right, left, front or back.

Nature of Injury (Please tick where applicable)

- | | |
|---|--|
| <input type="checkbox"/> Abrasions, Scratches | <input type="checkbox"/> Dislocations |
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Fractures |
| <input type="checkbox"/> Bums | <input type="checkbox"/> Sprains |
| <input type="checkbox"/> Bruises | <input type="checkbox"/> Crushing |
| <input type="checkbox"/> Lacerations, Cuts | <input type="checkbox"/> Others; Please specify: _____ |

Date of Return to work: (DD) (MM) (YYYY)

SECTION IV : DECLARATION OF WAGES

Note: Statement of wages of the Injured person earned IN THE PRESENT EMPLOYMENT for the twelve months immediately prior to the date of this Incident, or wages earned during such shorter period as he/she may have been in the Employer's service, stating the date on which he/she was engaged.

Month (MM/YYYY)	Gross Monthly Earnings (Excluding bonus)	Overtime pay, bonuses and allowance, Paid During Past 12 Months (Excludes transport allowances and reimbursements for expenses incurred by the injured person)

Total Monthly Average:

Average Monthly Earnings (Gross monthly + overtime pay, bonus and allowance):

I/We declare that the foregoing is true and correct to the best of our belief and knowledge.

SECTION V : DETAILS OF OTHER INSURANCE CLAIMS

Name of Insurer: _____

Policy No: _____

Type of Benefit/Plan _____

Date of Filed Claim (if any) (DD) (MM) (YYYY) _____

Amount Claimed: _____

PERSONAL INFORMATION COLLECTION STATEMENT

Allianz Insurance Singapore Pte. Ltd. ("Allianz" or "we" or "us"), believes that an individual's Personal Information should be handled with the utmost respect and we are committed to protecting their privacy and confidentiality.

1. Purpose Of Collecting Personal Data

We may use the personal data for the following purposes:

- (a) processing and evaluating your insurance application, including submitting your application for reinsurance purposes;
- (b) administering your insurance policy and providing services in relation to your insurance policy;
- (c) investigating, process and pay claims made under your insurance policy;
- (d) invoicing and collecting premiums and outstanding amounts from you;
- (e) verifying your identity;
- (f) detecting and preventing fraud;
- (g) carrying out market research for business insights;
- (h) conducting statistical analysis and profiling analysis;
- (i) conducting research and quality assurance;
- (j) responding to, handling, and processing queries, requests, applications, complaints, and feedback from you;
- (k) complying with any applicable laws, regulations, codes of practice, guidelines, or rules, or to assist in law enforcement and investigations conducted by any governmental and/or regulatory authority;
- (l) facilitating and managing business operations, including but not limited to disaster recovery, data entry and data storage; and
- (m) any other incidental business purposes related to or in connection with the above

2. Disclosure Of Personal Data

We may disclose or transfer, within or outside of Singapore, your personal data for the purposes set out above to:

- (a) our related or associated companies, insurance intermediaries, financial institutions, professional advisers, consultants and auditors;
- (b) insurers and reinsurers;
- (c) medical institutions and professionals;
- (d) industry associations;

- (e) debt collection agencies;
- (f) parties who assist us in claim investigation, administration and adjudication;
- (g) service providers, agents, contractors, delegates, suppliers or third parties (or subcontractors of the foregoing) which we may appoint from time to time to provide us with services in connection with the services that we offer to you, and their directors, officers, employees, representatives, agents or delegates. These service providers with whom we have contractual relationships are required to provide a standard of protection to the transferred personal data that is comparable to the protection under the Singapore Personal Data Protection Act 2012 and consistent with our personal data protection policies and practices; and
- (h) regulators, government agencies and law enforcement agencies.

3. Withdrawal Of Consent

The consent that you provide for the collection, use and disclosure of your personal data will remain valid until such time it is being withdrawn by you in writing. You may withdraw consent and request us to stop using and/or disclosing your personal data at any time for any or all of the purposes listed above by submitting your request in writing to our Data Protection Officer at the contact details provided below. Your withdrawal consent will take effect within 30 days of receiving your request. Consequently, we will cease to collect, use or disclose your Personal Information, unless it is required under the Personal Data Protection 2012 or any other written Applicable Laws. If you withdraw your consent to any of the above, we may not be able to provide you with the services that you have requested for and we will inform you of the consequences of such withdrawal of consent where applicable.

4. For Enquiries Relating To Personal Data Protection, Access Or Correction Of Your Personal Data, Please Write To Us At:

The Data Protection Officer
Allianz Insurance Singapore Pte. Ltd.
79 Robinson Road #09-01
Singapore 068897
Email: dpo@allianz.sg

DECLARATION

I/We hereby declare that I/We have complied with the policy Terms & Conditions, all information provided in this claim form and documents submitted are true, accurate and complete to the best of my knowledge. I/We certify that I/We have not withheld any material information. I/We understand that if I/we intentionally made any false or fraudulent statement or conceal any material fact, Allianz reserves the right to repudiate the claim. I/We undertake to advise Allianz promptly of all developments in connection with the claim.

I/We authorise the release of my/our medical information necessary to process this claim.

I/We hereby give consent to Allianz and its third parties service providers, related entities, business partners, employees and agents to collect, use, disclose and/or transfer, within or outside of Singapore, all personal data related to me and other individuals provided by me in this application for one or more abovementioned purposes. I/We warrant that I/We have obtained consent from the other individuals whom personal data furnished by me/us in this application for one or more abovementioned purposes.

I/We confirm that I/We understand and agree to the Personal Information Collection Statement.

Signature of
Injured Person:

Name of
Injured Person:

Signature of
Supervisor/Reporting Personnel:

Name of
Supervisor/Reporting Personnel:

Company Stamp:

Date:

DOCUMENTS REQUIRED FOR CLAIM ASSESSMENT

Kindly provide the following documents for us to assess your claim. Additional forms/information may be required under the Work Injury Compensation Act.

(Please tick against the documents you have submitted)

- iReport e-filed with the Ministry of Manpower
- Injured Person's Work Permit/ Identity Card
- Injured Person's pay history/ salary slips/ wage vouchers for the past 12 months before the date of incident
- Injured Person's pay history/ salary slips/ wage vouchers indicating the payout of entire light duty at work
- Injured Person's attendance records and/or duty roster covering the entire period of his/her medical leave which includes light duty (for shift work)
- Internal Investigation/ Incident Report(s)
- Police Report (if related to motor vehicle accident or any accident that requires such report to be lodged)
- Motor Accident Report for accidental injury cases when using own motor/ company vehicle in the course and/or out of the course of employment
- Hospital/ medical bill(s) and receipt(s)
- Medical Certificate(s) for Hospitalisation Leave, Outpatient Leave and/or Light Duty
- Inpatient Discharge Summary Report (if hospitalized) and all other relevant medical/ investigation /imaging reports
- Attending physician's note stating the extent of injury or disability
- Death Certificate (if applicable)
- Letter of Award and Contractual Agreement between the main contractor and sub-contractor for the designated project site work (if applicable)
- Tool-box meeting and attendance report

Note:

- Should there be any claim(s) settlement from another insurer, please provide claims settlement letter and detailed breakdown of claim(s) settled.
- Please be reminded to update the number of medical leaves in the MOM portal timely whenever the injured person is granted more medical leaves.