Underwritten by:

TOKIO MARINE

Mail to ⇨ **AVA INSURANCE BROKERS PTE LTD**
91 Bencoolen Street #08-03
Sunshine Plaza Singapore 189652
Tel: +65 65351828 Fax: +65 65356878
Company's Registration No. 200706523M
Website: www.ava-ins.com

GROUP PERSONAL ACCIDENT CLAIM FORM (SCHOOLS)

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 Tokio Marine Insurance Singapore Ltd shall be furnished at the expense of the Policyholder or Claimant.

POLICYHOLDER INFORMATION	
Name of Policyholder/Name of School:	Is policyholder GST Registered? ☐ YES ☐ NO If yes, is policyholder allowed to claim the GST on the Insurance Premium paid? ☐ YES ☐ NO
CLAIMANT INFORMATION *(to be completed by claimant)*	
Name of Claimant:	NRIC /Passport No:
Name of Parent/Legal Guardian:	NRIC /Passport No: Contact no. Mailling Address:
CHEQUE PAYEE NAME *(for Cheque Claims Processing)*	
Name of Cheque Payee:	
DETAILS OF ACCIDENT/INJURY	
Date & Time of Accident	Place of Accident:
How did Accident happen?	
Describe the nature of injuries sustained:	
Please provide: *a) Original medical bills and/or medical reports/memo from the attending doctor stating the nature of injury if you are treated as an outpatient as a result of an accident;* *b) original hospital final bill and inpatient discharge summary/medical report if you are hospitalized as a result of an accident.*	
NATURE OF CLAIM *(I am making a claim under the following sections, please tick the relevant)*	
Policy Benefits	
☐ Accidental Death	
☐ Permanent Disablement	
☐ Accidental Medical Expenses	

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 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 Tokio Marine Insurance reserves the right to repudiate the claim if it is later proven false or intentionally omitted by me.

I authorize the release of any medical information necessary to process this claim.

______________________________ Signature of Claimant

Date:

______________________________ Authorised Signature & Company Stamp of Policyholder

Date:

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(ONLY APPLICABLE FOR ACCIDENTAL MEDICAL CLAIM ABOVE $1,000)

MEDICAL REPORT – TO BE COMPLETED BY ATTENDING PHYSICIAN

Name of Patient:	NRIC No./Passport No.:

Are you the patient's usual medical doctor? ☐ Yes ☐ No

Have you attended him/her for any illness or accident before? ☐ Yes ☐ No

If Yes, state for what and when ____

Is condition due to ☐ Sickness ☐ Injury

After the accident, the first treatment was 1) When? ______________2) Where? _________________________

Was patient in your opinion, perfectly sober at the time of accident? ☐ Yes ☐ No

State as fully as possible the diagnosis of the illness/the nature and extent of injuries sustained :

____

____

Are the injuries on the right or left side? ____

In your opinion, are the injuries sustained in line with the accident that patient describe? ☐ Yes ☐ No

Is the patient now or was he/she at the time of accident, suffering from or affected by any physical infirmity, disease, or illness, irrespective of injuries? ☐ Yes ☐ No

If yes, 1) state nature ____

2) extent it impede the recovery of patient ____

Is patient suffering from or does he/she suffered from any cardiac affection, gout, rheumatism, or fits of any kind? ☐ Yes ☐ No

Are you aware of anything in the previous medical history of the patient which might have contributed directly or indirectly, to the occurrence of the accident, or which may be likely in any what to retard his/her recovery from it?

____

Whether the injuries sustained will result in any permanent disablement/incapacity. If so, please advise percentage of disablement/incapacity.

I hereby certify that I have personally examined and treated the patient for the above illness/injuries and that the facts as given above present my opinion of the patient's condition.

Signature of Physician/Surgeon : _________________________ Date: ___________

Name & Designation : ____

Name & address of clinic/hospital : ____