中国太平 CHINA TAIPING

中国太平保险(新加坡)有限公司
CHINA TAIPING INSURANCE (SINGAPORE) PTE. LTD.
3 Anson Road #16-00 Springleaf Tower Singapore 079909
Tel: 6389 6111 Fax: 6222 1033
Website: www.sg.cntaiping.com
Co. Reg. No. 200208384E

NOTICE OF CLAIM UNDER PERSONAL ACCIDENT POLICY

1	Name of Claimant (in full)					Policy No	
	Address						
	Present Business or Occupation					Present Age	
	Amount Insured	$		Identity Card No		Passport No	
2	Date & Time of Accident		2	Date		Time	
3	Place Accident Occurred		3				
4	Please state how the accident occurred and what you were doing at the time		4				
5	Were you perfectly sober at the time of the accident?		5				
6	Please state as precisely as you can the injuries you have sustained		6				
7	Please give names and addresses of any persons who witnessed the accident.		7	Name		Address	
			1)				
			2)				
			3)				
8 a	Please give name and address of Medical Practitioner who attended you after the accident		8 a				
b	What is the probable period of disablement?		b				
9 a	Whether you have been totally unable to attend to any portion of your business. If so, please give dates.		9 a	(1) From		To	
	(1) In bed						
	(2) Confined to house			(2) From		To	Inclusive

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b	On what dates you were able to attend to your usual business or occupation	b	
10	Please state whether in respect of the accident you are entitled to receive compensation from any other source. If so, from what source and to what extent?	10	
11	Have you ever made a claim for compensation in respect of Accidental injury from any Insurance Company or Underwriter? If so, please give particulars.	11	

DATA PRIVACY STATEMENT

In accordance with the Personal Data Protection Act 2012, I consent to the collection, use, disclosure of and/or process of my personal data (whether contained in the Claim Form or otherwise obtained) by China Taiping Insurance (Singapore) Pte Ltd, its affiliates and service providers (within or outside Singapore), for the purpose relating to the evaluation of the claim and to provide advice and information relating to the claim to me by Short Message Service (SMS), Multimedia Messaging Service (MMS) and fax messages (notwithstanding the registration of my telephone or mobile number in the Singapore's Do Not Call Registry)

Yes, I have read and agreed to the above Data Privacy Statement.

Date _____ Signature of Claimant _____

N.B. 1 The issue of this form is not an admission of liability by the Company.
2 If the Claimant is unable to fill up this form personally it may be filled up on behalf of the Claimant.
3 Please have your Medical Attendant complete the Medical Certificate on back of this form.

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MEDICAL CERTIFICATE

The Claimant must obtain at his own expense the following certificate from his Medical Attendant.
The Medical Attendant is requested to state:-

1	Are you his usual Medical Attendant, and if so how long have you Known him?	1				
2	The date you first attended the Claimant in respect of the injuries sustained in consequence of the above accident.	2				
3	Whether you are still attending the Claimant.	3				
4 a	How long the Claimant has been confined as a result of the accident above referred to To his bed	4 a				
b	To his house	b				
5 a	Give particulars of the injuries sustained. Regions injured. (If a hand or an arm, a foot or a leg, state whether it is the right of left)	5 a				
b	Nature and extent or injuries.	b				
c	Are the symptoms from which he suffers due to (1) the accident alone or	c	(1)			
	(2) are they traceable to any other cause?		(2)			
6	Have you any reason to think that the Claimant was otherwise than perfectly sober at the time of the accident?	6				
7	Are you aware of anything in his previous medical history which have contributed, directly or indirectly, to the occurrence of the accident, or which may be likely to retard in any way his recovery from it?	7				
8	Whether Claimant is now or was at the time of the accident suffering from any physical defect or illness irrespective of his injuries. If so, please state nature thereof.	8				
9	If still confined to bed or house probable further period he will be so confined.	9				
10 a	To what extent the Claimant has been totally disabled from following his occupation as shown on the face of this form	10 a	From		To	
b	To what extend the Claimant has been partially disabled from following his occupation as shown on the face of this form	b	From		To	
11	Whether the Claimant is now attending to his business in any way.	11				
12	If disablement is at an end, please state on what date is ceased.	12				
13	General Remarks					

I hereby certify that the foregoing statements are correct.

Signature _____

Date _____ *Address* _____

Qualifications _____