

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? <input type="checkbox"/> YES <input type="checkbox"/> NO
	If yes, is policyholder allowed to claim the GST on the Insurance Premium paid? <input type="checkbox"/> YES <input type="checkbox"/> 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	
<input type="checkbox"/> Accidental Death	
<input type="checkbox"/> Permanent Disablement	
<input type="checkbox"/> 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:

Underwritten by:



TOKIO MARINE

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

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

**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 : \_\_\_\_\_