



ace insurance

**ACE Insurance Limited**

Co Regn No: 199702449H  
600 North Bridge Road #04-02 Parkview Square Singapore 188778  
Tel: 65-6398 8000 Fax: 65-6293 4058

**PERSONAL ACCIDENT CLAIM FORM**

The acceptance of this Form is NOT an admission of liability on the part of the Company.

SECTION A - PARTICULARS OF INSURED AND INSURED PERSON			
Name & Address of Insured:	Tel. No. (Office):	Tel. No. (Residence):	
	Policy No.:	Period of Insurance:	
	E-mail Address:	Name of Intermediary (if any):	
Name & Address of Insured Person:	Tel. No. (Office):	Tel. No. (Residence):	
	Date of Birth:	Occupation:	
	E-mail Address:	Date of Employment:	
		Sex: ( ) Male ( ) Female	
SECTION B - PARTICULARS OF THE ACCIDENT			
Explain exactly on how did the accident occur:	Country of occurrence: ( ) Singapore ( ) Malaysia ( ) Others: _____		
	Place of loss or occurrence:		
	Date of Loss:	Time of loss:	
	On when and by whom was the loss discovered:	Relationship:	
	Name & Address of any witnesses of the incident:	NRIC/Passport No.:	
		Contact No.:	
SECTION C - NATURE OF INJURY			
1. Describe in details the injuries sustained, indicating the part of the body injured and the type of injury (eg. Fracture, cut, bruise, etc.)			
2. Name and Address of doctor(s) who treated you and consultation date(s).			
3. Name and Address of your usual family physician.			
4. Details of hospitalization (please attach discharge note & hospital bill):			
(a) Name of hospital	(a)		
(b) Period of hospitalisation	(b) Date Admitted: _____ Date Discharged: _____		
5. Details of Temporary Disability from engaging in or attending to your usual business as a result of the injuries.			
(a) light duties	(a) from _____ to _____		
(b) medical leave	(b) from _____ to _____		
6. Date returned/expected to return to work.			
SECTION D - ANY OTHER INSURANCES			
Are you claiming from any other insurance company or other insurance company or other sources in respect of this injury?. If yes, state:			
Name of Insurance Company	Policy No.	Amount of Benefits	
		Date Insurance Effected	



**DECLARATION AND AUTHORISATION**

1. I/We declare that the above information is true and complete to the best of my knowledge and belief.
2. I/We hereby authorize any doctor or any other person who has ever medically attended to the Insured Person, or any Hospital in which he or she has been treated to disclose any relevant knowledge or information which they acquired, to ACE Insurance Limited or their Authorised Representative.
3. I/We hereby request and authorize ACE Insurance Limited to pay benefit due in respect of this claim to: \_\_\_\_\_  
(other than Insured)

Insured Person's signature: \_\_\_\_\_ Date: \_\_\_\_\_ Insured's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Note: If (a) The Insured is claiming on his own belief or (b) the Insured Person concerned is a Child under 18 years of age – only the Insured's signature is required.

**Attending Physician's Statement**  
(TO BE COMPLETED BY ATTENDING PHYSICIAN)

Name of Patient:	I.C. No.:	Date of Birth:
1. Date on which you first saw the patient.		
2. Is condition due to injury or Sickness?	<input type="checkbox"/> Sickness <input type="checkbox"/> Accident on _____ (D/M/Y)	
3. Was the patient referred to you by another doctor? If so, please furnish Name and Address of referral doctor.		
4. (a) Of what symptoms did the patient complain?  (b) According to the patient, how long had he/she been experiencing these symptoms?	(a)  (b)	
5. In your opinion, how long do you feel the symptoms had lasted?		
6. Had the patient previously seen any other doctor or receive treatment on account of these symptoms? If so, please give details.		
7. (a) What was your final diagnosis?  (b) Does injury results in fracture of bones? If yes, which part of the body?	(a)  (b) <input type="checkbox"/> No <input type="checkbox"/> Yes - Simple Fracture <input type="checkbox"/> Compound Fracture	
8. Did Injury or Sickness require:  (a) hospitalization?  (b) X-rays? (c) Special diagnostic procedure? (d) Surgery?	(a) <input type="checkbox"/> No <input type="checkbox"/> Yes Date Admitted: _____ Date Discharged: _____ (b) <input type="checkbox"/> No <input type="checkbox"/> Yes (c) <input type="checkbox"/> No <input type="checkbox"/> Yes (d) <input type="checkbox"/> No <input type="checkbox"/> Yes Type of Surgery: _____	
9. Is patient still under your care for this condition?	(a) <input type="checkbox"/> No <input type="checkbox"/> Yes	
10. Bearing in mind the patient's occupation as stated overleaf, do you feel that the injuries or sickness would have prevented him from working?		
11. How long was or will patient be continuously totally disabled (unable to work)?		
12. How long was or will patient be partially disabled?		
13. Give details of any circumstances, such as intoxication, physical defects or medical history which may have contributed to the accident or sickness and/or lengthen the period of disability.		
I hereby certify that I have personally examined and treated the patient for the above * injury/sickness and that the facts as given above present my opinion of his/her condition.		
Name of Physician : _____	Qualification : _____	
Official address : _____	Tel : _____	
_____	Fax : _____	
Signature with official stamp : _____	Date : _____	

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