

WORK INJURY COMPENSATION REPORT

1 Important Notice

1. This form is issued without admission of liability under the Policy. If a workplace injury occurs, you must complete and submit this form immediately, whether or not a claim is made.
2. Each question must be answered. You must provide all relevant information. A failure to comply with this requirement may prejudice any claim you make.
3. If the accident is or may be the subject of a Common Law action, you must immediately provide all documents or correspondence received from lawyers acting for the injured worker. Further, **you must not**, in any circumstances, **make any admission of liability** whatsoever.
4. A consent form authorising the release of medical information forms part of this Injury Report. If possible, please arrange for the injured worker to sign the consent form.

2 Employer/Policyholder's Details

Name of Policy Holder _____

Trading name (if different) _____

Telephone No. _____ Fax No. _____

Email address _____

Are there any other policies that may cover you for this accident? Yes No

3 Injured Worker's Details

Name _____

Gender Male Female Date of Birth _____

Citizenship _____ NRIC/FIN/Passport No. _____

Home address _____

Contact No. _____

3 Employment Details

Is the Injured worker your direct employee? Yes No

If No, give details of direct employer _____

What is the worker's usual occupation? _____

Was the worker engaged in this occupation when the accident occurred? Yes No

If No, provide details _____

Basis of the worker's employment Full-time Part-time Casual Other

If full-time did the worker work 5.5 or 6 days per week? _____

When did this worker first commence employment with you? _____

Did the worker suffer from any pre-existing injury or disability? Yes No

If Yes, give details _____

Please list the average monthly income of the Worker for the 12 months preceding the accident:

Month	Gross earnings excluding bonus and overtime	Additional Payments/Bonus amounts received
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Total (Column 1) _____ (Column 2) _____

Average [(Column 1 + Column 2)/12] _____

5 Details of the Accident

Date _____ Time _____ a.m. / p.m.

Date the accident was reported to you _____

Where did the accident occur? _____

How did the accident occur? _____

Do you believe that the worker, or any other third party (such as the manufacturer or supplier of relevant equipment) caused or contributed to the accident? Yes No

If Yes, provide the name and contact details of that person/third party? _____

Was the worker, or any other person involved in the accident, under the influence of liquor/drugs?

Yes No

Was the worker injured due to his/her own misconduct or failure to follow instructions?

Yes No

Was anyone supervising the worker at the time of the accident? Yes No

If Yes, please give details of supervisor

Name _____ Designation _____

Was the accident reported to MOM?

Yes No

PLEASE ATTACH A COPY OF THE MOM INCIDENT REPORT NOTICE TO THIS FORM.

6 Injuries Sustained by the Worker

Please provide details of the injuries suffered by the worker (e.g. fractures, bruising, lacerations)

Date the worker ceased work _____

Name of Hospital/Clinic where the worker was treated _____

Was the worker an IN-PATIENT or an OUT-PATIENT? _____

On what date was the worker discharged from hospital? _____

Is the worker still undergoing medical treatment? Yes No

Has the worker returned to work? Yes No

If Yes, what date did the worker resume work? _____

If No, when is the worker likely to be able to return to work? _____

7 Witness Details

Please provide details of any witness to the accident:

Name _____ NRIC/FIN/Passport No. _____

Address _____

Contact no. _____

If there was more than one witness, please provide their details on a separate piece of paper and attach to this Injury Report.

8 Other Comments

Please provide any other comments about the accident or any person involved:

9 Declaration

I/We declare that the information shown on this form is true and correct to the best of My/Our knowledge and belief and that I/We have not concealed any information relevant to the reported accident.

Signature and Stamp of the policyholder

Date

REMINDER: PLEASE ATTACH A COPY OF THE MOM INCIDENT REPORT.

Release and Disclosure of Medical Information

To be completed by the injured worker.

For the purposes of this authorisation, a reference to Liberty International Underwriters (“LIU”) includes its service providers, representatives and agents.

1. I authorise any hospital, doctor, clinic and other healthcare practitioner who has attended upon or examined me for any reason to:
 - a) disclose to LIU all information with respect to any injury, sickness or treatment (whether the subject of this claim or otherwise); and
 - b) provide to LIU a copy of any medical reports, hospital/clinical records arising from or associated with any such injury, sickness or treatment.
2. I authorise LIU to disclose my personal information (including medical reports and hospital/clinical records) to any medical practitioner, legal practitioner and any other service provider, expert or consultant for the purpose of determining and managing my claim.
3. A photostat copy of this authorisation shall be as effective and valid as the original.

Signature of injured worker

Date

Privacy Notice

We collect personal information in order to provide our services and products. We also pass it to third parties involved in this process such as our reinsurers, loss adjusters and lawyers.

When you give us personal or sensitive information about other individuals, we rely on you to have made or make them aware that you will or may provide their information to us, the purposes we use it for, the types of third parties that we disclose it to and how they can access it.

If it is sensitive information we rely on you to have obtained their consent on these matters. If you have not done either of these things, please inform us before you provide the relevant information.