Allianz Global Corporate & Specialty SE
Singapore Branch
Company Registration No.: T11FC0131K
Address: 12 Marina View, #14-01 Asia Square Tower 2, Singapore 018961
Tel: +65. 6297 2529 Fax: +65. 6297 1956
Website: http://www.agcs.allianz.com

Allianz Contact Centre
Tel: 1800 222 1818
Email: claims@allianz.com.sg

PERSONAL ACCIDENT CLAIM FORM

THE POLICYHOLDER / CLAIMANT IS REQUESTED TO NOTE:

(a) This form must be completed truthfully and accurately.

(b) This form must be filled up and delivered to the Company by email or by post together with all supporting documents in Appendix 1 as soon as possible.

(c) Please provide a copy of the marriage certificate and/or the birth certificate for policy bought under a family/child plan. If this is a personal policy only for yourself, a copy of the NRIC/work permit (back and front) is sufficient.

(d) Please state all relevant information requested in this claim form, as complete and accurate as possible together with the supporting documents required. Any documents or reports required to process this claim shall be furnished at the expense of the Policyholder or Claimant.

(e) The list of documents required is not exhaustive and we may require or request from you additional information/documentation as necessary to process your claim. The submission of an incomplete form, insufficient information or documentation may delay the processing or result in the denial of your claim.

(f) If the claim is found to be fraudulent, or if any fraudulent means or devices are used to obtain any benefit under the policy, your claim may be declined and all benefits under your policy may be forfeited.

(g) The issuance or acceptance of this form is not an admission of liability by the Company.

Type of claim: ☐Medical Expense ☐Hospital Cash ☐Weekly Benefit ☐Disease Benefit

☐Mobility Aids/Home Modification ☐Child's Education Fund ☐Total/Partial Disability ☐Accidental Death

Claim submission: ☐New claim ☐Add-on claim with claim no: ________________________________

Section I: Policyholder Information

Policy No:	Name of Policyholder (As per NRIC / FIN):	NRIC / FIN No:
Contact Details: (Mobile) (Home) (Email)		Gender: ☐Male ☐Female
Correspondence Address:		Occupation:

Section II: Claimant Information (if different from Policyholder)

Name of Claimant (As per NRIC / FIN)	NRIC / FIN No:
Contact Details: (Mobile) (Home) (Email)	Gender: ☐Male ☐Female
Correspondence Address:	Occupation:
Relationship between Claimant and Policyholder:	

Section III: Injury / Disease / Accident Information

Date & Time of Injury / Disease / Accident:	DD	MM	YYYY	
	Hours	Mins	☐ AM	☐PM
Where and how did the injury / disease / accident occur? In the case of disease, when did the symptom(s) appear and what were the symptom(s)?				
Nature and extent of the injury & part of the body affected:				

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If you had a history of a similar injury / disease / accident before, please give details of insurer, date of diagnosis and type of treatment received. Please specify recovery date (if any).	
Is this a work related injury / disease / accident? ☐Yes ☐No	If yes, please state the name of the insurance company for Work Injury Insurance and the policy no.
Was the injury / accident due to any person's fault? If yes, please provide name, address and contact no. of the other party/insurance company.	
Name and address of any witness of the accident	

Section IV: Medical Information

Name of Clinic / Hospital:	Contact no:	Address:
Admission Date: DD MM YYYY	Discharged Date:	DD MM YYYY
Diagnosis and type of treatment received		No. of MC days:

Name of Clinic / Hospital:	Contact no:	Address:
Admission Date: DD MM YYYY	Discharged Date:	DD MM YYYY
Diagnosis and type of treatment received		No. of MC days:

Name of Clinic / Hospital:	Contact no:	Address:
Admission Date: DD MM YYYY	Discharged Date:	DD MM YYYY
Diagnosis and type of treatment received		No. of MC days:

Name of Clinic / Hospital:	Contact no:	Address:
Admission Date: DD MM YYYY	Discharged Date:	DD MM YYYY
Diagnosis and type of treatment received		No. of MC days:

Section V: Details of other Insurance claims

Name of insurer	Policy no.	Type of benefit	Date of filed claim (if any)	Amount claimed

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PERSONAL INFORMATION COLLECTION STATEMENT

Allianz Global Corporate & Specialty SE Singapore Branch, ("Allianz" or "we" or "us"), believes that an individual's Personal Information should be handled with the utmost respect and we are committed to protecting their privacy and confidentiality.

1. **Purpose of collecting personal data**
We may use the personal data for the following purposes:

(a) processing and evaluating your insurance application;

(b) administering your insurance policy and providing services in relation to your insurance policy;

(c) investigate, process and pay claims made under your insurance policy;

(d) invoicing and collecting premiums and outstanding amounts from you;

(e) verifying your identity;

(f) detect and prevent fraud;

(g) reinsurance purposes;

(h) statistical analysis, research and quality assurance;

(i) responding to, handling, and processing queries, requests, applications, complaints, and feedback from you;

(j) complying with any applicable laws, regulations, codes of practice, guidelines, or rules, or to assist in law enforcement and investigations conducted by any governmental and/or regulatory authority;

(k) disaster recovery, data entry and data storage; and

(h) any other incidental business purposes related to or in connection with the above.

2. **Disclosure of personal data**
We may disclose or transfer, within or outside of Singapore, your personal data for the purposes set out above to:

(a) our related or associated companies, insurance intermediaries, financial institutions, professional advisers, consultants and auditors;

(b) insurers and reinsurers;

(c) medical institutions and professionals;

(d) industry associations;

(e) debt collection agencies;

(f) parties who assist us in claim investigation, administration and adjudication;

(g) service providers, agents, contractors, delegates, suppliers or third parties (or subcontractors of the foregoing) which we may appoint from time to time to provide us with services in connection with the services that we offer to you, and their directors, officers, employees, representatives, agents or delegates. These service providers with whom we have contractual relationships are required to provide a standard of protection to the transferred personal data that is comparable to the protection under the Singapore Personal Data Protection Act 2012 and consistent with our personal data protection policies and practices; and

(h) regulators, government agencies and law enforcement agencies.

3. **Withdrawal of consent**

The consent that you provide for the collection, use and disclosure of your personal data will remain valid until such time it is being withdrawn by you in writing. You may withdraw consent and request us to stop using and/or disclosing your personal data for any or all of the purposes listed above by submitting your request in writing to our Data Protection Officer at the contact details provided below. If you withdraw your consent to any of the above, we may not be able to provide you with the services that you have requested for and we will inform you of the consequences of such withdrawal of consent where applicable.

4. **For enquiries relating to Personal Data Protection, access or correction of your personal data, please write to us at:**

The Data Protection Officer
Allianz Global Corporate & Specialty SE Singapore Branch
12 Marina View
#14-01 Asia Square Tower 2
Singapore 018961
Email: dpo_sg@allianz.com

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DECLARATION

I/We hereby declare that I/We have complied with the policy Terms & Conditions, all information provided in this claim form and documents submitted are true, accurate and complete to the best of my knowledge. I/We certify that I/We have not withheld any material information. I/We understand that if I/we intentionally made any false or fraudulent statement or conceal any material fact, Allianz reserves the right to repudiate the claim. I/We undertake to advise Allianz promptly of all developments in connection with the claim.

I/We authorize the release of my/our medical information necessary to process this claim.

I/We hereby give consent to Allianz and its third parties service providers, related entities, business partners, employees and agents to collect, use, disclose and/or transfer, within or outside of Singapore all personal data related to me and other individuals provided by me in this application for one or more above mentioned purposes. I/We warrant that I/We have obtained consent from the other individuals whom personal data furnished by me/us in this application for one or more abovementioned purposes.

I/We confirm that I/We understand and agree to the Personal Information Collection Statement.

Signature of Claimant:………………………………………..

Name of Claimant:……………………………………………

Date:………………………………

Signature of Policyholder:……...

Name of Policyholder:………………………………………….

Date:………………………………

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APPENDIX I: Documents required for claims submission

Kindly provide the following documents for us to assess your claim.

Additional information may be required for further verification.

Medical Expenses / Hospital cash
- ☐ Original hospital/medical bills and receipt(s) with proof of diagnosis
- ☐ Inpatient Discharge Summary report and all other relevant medical reports, if hospitalised
- ☐ Original invoice for ambulance fee/transportation services to hospital
- ☐ Copy of Police report (if related to Motor vehicle accident or any accident that requires such report to be lodged)
- ☐ Driver's driving license, if driving at the time of the accident

Weekly Cash Benefits
- ☐ Medical report or relevant medical records for certification of temporary disablement
- ☐ Copy of Medical Sick Leave (MC)
- ☐ Copy of Police report (if related to Motor vehicle accident or any accident that requires such report to be lodged)
- ☐ Driver's driving license, if driving at the time of the accident

Disease Benefit
- ☐ Medical report or relevant medical records stating the diagnosis

Mobility Aid/Modification benefits (payable only upon a major disability)
- ☐ Original bills and receipt(s) with clear description of the item purchased or treatment sought
- ☐ Doctor's memo, referral letter or recommendation certifying the need for the purchase of the mobility aid or home modification required
- ☐ Medical report or relevant medical records stating the diagnosis

Child's Education Fund (payable only upon accidental death of insured)
- ☐ Copy of Police report (if related to Motor vehicle accident or any accident that requires such report to be lodged)
- ☐ Driver's driving license, if driving at the time of the accident
- ☐ Copy of death certificate
- ☐ Copy of post-mortem Report
- ☐ Grant of Probate & Letters of Administration
- ☐ Copy of Birth Certificates of Insured and the dependents

Total/Partial Disability
- ☐ Copy of Police report (if related to Motor vehicle accident or any accident that requires such report to be lodged)
- ☐ Driver's driving license, if driving at the time of the accident
- ☐ Medical report or relevant medical records for certification of total/partial disablement

Accidental Death
- ☐ Copy of Police report (if related to Motor vehicle accident or any accident that requires such report to be lodged)
- ☐ Driver's driving license, if driving at the time of the accident
- ☐ Certified true copy of death certificate
- ☐ Copy of post-mortem Report and/or autopsy report including Toxicology Report
- ☐ Copy of Coroner's Inquest Verdict, if any
- ☐ Grant of Probate & Letters of Administration

Note: Should there be any claim(s) settlement from another insurer, please provide claims settlement letter and detailed breakdown of claim(s) settled.