Etiqa Insurance Pte. Ltd. (Company Reg. No. 201331905K)
One Raffles Quay #22-01 North Tower Singapore 048583 | T +65 6336 0477 | F +65 6339 2109 | www.etiqa.com.sg

ePROTECT *family* Claim Form

Policy No.		Name of Insured Person	

Important Notice

1. The policyholder and/or the claimant must truthfully declared the information and particulars to the best of your / their knowledge and belief.
2. The acceptance of this form is not in itself an admission of liability on the part of the Company.
3. If the claim is found to be fraudulent, or if any fraudulent means or devices are used to obtain any benefit under this policy, the policy will be rendered void.

The Claimant

Name of Claimant				Passport/NRIC or Birth Certificate No.	
Residential Address				Residential Tel No.	
Business Address				Business Tel No.	
Occupation / Business		Present Age	years	Mobile No.	

Details of Accident

State when and where the Accident occurred:

Date Time Place

State full circumstances of the Accident

State: (a) What injuries you have sustained.

(b) Whether you have ever had an injury to the same part before.

Are you claiming, or entitled to claim, compensation for this Accident from any other Company or Society? ☐ Yes ☐ No
If YES, please state the name (s).

Give the names and addresses of any Witnesses of the Accident.

Give the name and address of the doctor who attended to you on your meeting with the Accident.

Is he your usual doctor? ☐ Yes ☐ No

Has he, or any other Medical Practitioner, attended to you during the last ten years for any illness or injury? ☐ Yes ☐ No
If YES, please give particulars.

Have you, as the direct result of the Accident, been totally incapacitated from attending to business of any kind? ☐ Yes ☐ No
If YES, please state for how long.

From To

Are you still totally incapable of attending to business of any kind? ☐ Yes ☐ No

State if (a) confined to bed
(b) confined to the house
(c) able to get out of doors

If you are now able to attend to any portion of your business or occupation, state when you commenced to do so.

Date

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Have you now fully resumed your usual business or occupation? If YES, please state since when. Date	☐ Yes ☐ No
When and where can you be visited by the Medical or other Officer of the Company? Date Time Place	

Declaration

1) I/We declare that the information given in this claim is true and correct to the best of my/our knowledge and belief.
2) I/We further declared that the information written in this claim form or held by Etiqa Insurance Pte. Ltd. whether contained in my/our insurance application or otherwise obtained may be used and disclosed to your authorised staff, associated individuals and/or companies or any independent third parties (within or outside Singapore) who will provide claims administrative, advice and/or information or claims services in relation to my/our claim. I/We understand my/our data that may also be used for audit, business analysis and reinsurance purposes. My/Our signature below will signify this consent.

Date

Signature of Insured
Company's stamp (if applicable)