



## CLAIM FORM

# Group Personal Accident

### General Information

This form must be completed truthfully and accurately.

The list of documents required is not exhaustive and we reserve our right to request from you any additional information/documentation, as necessary. The submission of an incomplete form or insufficient information or supporting documents may delay the processing or result in the denial of your claim.

The completed form should be returned together with all supporting documents as soon as possible to the following address:

AIG Asia Pacific Insurance Pte. Ltd.  
AIG Building 78 Shenton Way #09-16 Singapore 079120

The acceptance of this Form is NOT an admission of liability on the part of AIG Asia Pacific Insurance Pie. Ltd. ("AIG"), Any documentary proof or report required by AIG shall be furnished at the expense of the Policyholder or Claimant.

Please note that information you provide in this claim form will be used for the purposes of claims administration as outlined in this form and will not be used to update any of your existing records that our organization holds. If you wish for us to update any of your information in our records, please contact our Customer Care Consultants at 6419 3000, Mondays to Fridays, between 9am and 5pm. Alternatively, you may send us an email via [www.aig.sg/contact-online](http://www.aig.sg/contact-online)

### Policy Holder Information

Product Name and Plan			
Certification / Policy No.			
Policy Holder's Name			
Contact Details	Office	Mobile	Email
Nature of Business			

### Claimant Information

Insured Person's Full Name	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		
Identity Card / Passport No.			
Are You a US Citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If 'Yes', Please Provide Your Social Security No. (SSN).	
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female
Contact Details	Residential	Mobile	
	Email		

Designation/Title									
Class Type (e.g. Category)									
Date Insured Person Joined the Company	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
Name of Company									
Plan and/or Category of Employee									
Relation to Policy Holder									

**To be Completed by Agent/Broker (if applicable)**

Producer Code		Branch	
Name of Producer / Company Name			
Contact Person		Mobile No.	
Email Address			

**Accident Related Claim Only**

Type of Disablement Claim	<input type="checkbox"/> Permanent Total Disablement <input type="checkbox"/> Permanent Partial Disablement <input type="checkbox"/> Weekly Benefit for Temporary Total Disablement <input type="checkbox"/> Accident Medical Reimbursement <input type="checkbox"/> Accidental Death <input type="checkbox"/> Others (please specify)															
a) Date & Time of Accident	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> <td>H</td><td>H</td><td>:</td><td>M</td><td>M</td> <td><input type="checkbox"/> AM</td> <td><input type="checkbox"/> PM</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y	H	H	:	M	M	<input type="checkbox"/> AM	<input type="checkbox"/> PM
D	D	M	M	Y	Y	Y	Y	H	H	:	M	M	<input type="checkbox"/> AM	<input type="checkbox"/> PM		
(b) Where did the accident occur?																
(c) How did the accident occur?																
(d) Injuries Sustained																
(e) If you had a history of similar injury, which you have experienced in the past, please give details as to when, where and from whom you received medical diagnosis, treatment, consultation or prescribed drug.																

(f) Disablement Commencement	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; text-align: center;">D</td><td style="border: 1px solid black; width: 20px; text-align: center;">D</td><td style="border: 1px solid black; width: 20px; text-align: center;">M</td><td style="border: 1px solid black; width: 20px; text-align: center;">M</td><td style="border: 1px solid black; width: 20px; text-align: center;">Y</td><td style="border: 1px solid black; width: 20px; text-align: center;">Y</td><td style="border: 1px solid black; width: 20px; text-align: center;">Y</td><td style="border: 1px solid black; width: 20px; text-align: center;">Y</td> <td style="border: 1px solid black; width: 20px; text-align: center;">H</td><td style="border: 1px solid black; width: 20px; text-align: center;">H</td><td style="border: 1px solid black; width: 20px; text-align: center;">:</td><td style="border: 1px solid black; width: 20px; text-align: center;">M</td><td style="border: 1px solid black; width: 20px; text-align: center;">M</td> <td style="width: 20px; text-align: center;"><input type="checkbox"/> AM</td> <td style="width: 20px; text-align: center;"><input type="checkbox"/> PM</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y	H	H	:	M	M	<input type="checkbox"/> AM	<input type="checkbox"/> PM															
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g) Date of Death	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; text-align: center;">D</td><td style="border: 1px solid black; width: 20px; text-align: center;">D</td><td style="border: 1px solid black; width: 20px; text-align: center;">M</td><td style="border: 1px solid black; width: 20px; text-align: center;">M</td><td style="border: 1px solid black; width: 20px; text-align: center;">Y</td><td style="border: 1px solid black; width: 20px; text-align: center;">Y</td><td style="border: 1px solid black; width: 20px; text-align: center;">Y</td><td style="border: 1px solid black; width: 20px; text-align: center;">Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y																						
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(h) Are you still suffering the above stated disability?	<p>If yes, please advise the expected date &amp; time of returning to work.</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; text-align: center;">D</td><td style="border: 1px solid black; width: 20px; text-align: center;">D</td><td style="border: 1px solid black; width: 20px; text-align: center;">M</td><td style="border: 1px solid black; width: 20px; text-align: center;">M</td><td style="border: 1px solid black; width: 20px; text-align: center;">Y</td><td style="border: 1px solid black; width: 20px; text-align: center;">Y</td><td style="border: 1px solid black; width: 20px; text-align: center;">Y</td><td style="border: 1px solid black; width: 20px; text-align: center;">Y</td> <td style="border: 1px solid black; width: 20px; text-align: center;">H</td><td style="border: 1px solid black; width: 20px; text-align: center;">H</td><td style="border: 1px solid black; width: 20px; text-align: center;">:</td><td style="border: 1px solid black; width: 20px; text-align: center;">M</td><td style="border: 1px solid black; width: 20px; text-align: center;">M</td> <td style="width: 20px; text-align: center;"><input type="checkbox"/> AM</td> <td style="width: 20px; text-align: center;"><input type="checkbox"/> PM</td> </tr> </table> <p>If no, please advise the date &amp; time of returning to work.</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; text-align: center;">D</td><td style="border: 1px solid black; width: 20px; text-align: center;">D</td><td style="border: 1px solid black; width: 20px; text-align: center;">M</td><td style="border: 1px solid black; width: 20px; text-align: center;">M</td><td style="border: 1px solid black; width: 20px; text-align: center;">Y</td><td style="border: 1px solid black; width: 20px; text-align: center;">Y</td><td style="border: 1px solid black; width: 20px; text-align: center;">Y</td><td style="border: 1px solid black; width: 20px; text-align: center;">Y</td> <td style="border: 1px solid black; width: 20px; text-align: center;">H</td><td style="border: 1px solid black; width: 20px; text-align: center;">H</td><td style="border: 1px solid black; width: 20px; text-align: center;">:</td><td style="border: 1px solid black; width: 20px; text-align: center;">M</td><td style="border: 1px solid black; width: 20px; text-align: center;">M</td> <td style="width: 20px; text-align: center;"><input type="checkbox"/> AM</td> <td style="width: 20px; text-align: center;"><input type="checkbox"/> PM</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y	H	H	:	M	M	<input type="checkbox"/> AM	<input type="checkbox"/> PM	D	D	M	M	Y	Y	Y	Y	H	H	:	M	M	<input type="checkbox"/> AM	<input type="checkbox"/> PM
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D	D	M	M	Y	Y	Y	Y	H	H	:	M	M	<input type="checkbox"/> AM	<input type="checkbox"/> PM																	
(i) Have you sustained any fractures from this accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please advise the type of fracture:																														
(j) Have you sustained a burn injury from this accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following information: <input type="checkbox"/> Head <input type="checkbox"/> Body Degree of burn																														
(k) Have you lodged a police report?	<input type="checkbox"/> Yes <input type="checkbox"/> No    Date of report <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; text-align: center;">D</td><td style="border: 1px solid black; width: 20px; text-align: center;">D</td><td style="border: 1px solid black; width: 20px; text-align: center;">M</td><td style="border: 1px solid black; width: 20px; text-align: center;">M</td><td style="border: 1px solid black; width: 20px; text-align: center;">Y</td><td style="border: 1px solid black; width: 20px; text-align: center;">Y</td><td style="border: 1px solid black; width: 20px; text-align: center;">Y</td><td style="border: 1px solid black; width: 20px; text-align: center;">Y</td> </tr> </table> Police Station that you lodged report?	D	D	M	M	Y	Y	Y	Y																						
D	D	M	M	Y	Y	Y	Y																								
(l) Name and address of any witness of the incident																															
(m) Was the sum insured or benefits of your policy based on your monthly salary?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please advise the last drawn salary prior to the accident.																														

n) Please furnish the details of any hospitalisation in connection with this injury.

Name of Hospital	Admission Date (DD-MM-YYYY)	Date Discharged (DD-MM-YYYY)	Admission No.	Type of Ward

(o) Please provide information on your first consultation.

Doctor Consulted			
Doctor's Address			
Doctor's Contact No.		Doctor's File Ref No. (If applicable)	

(p) Please provide information of your regular doctor.

Regular Doctor			
Regular Doctor's Address			
Regular Doctor's Contact No.		Doctor's File Ref No. (If applicable)	

### Sickness Related Claim Only

#### Claim Description (fill in items that apply)

(a) Give a brief description of the sickness suffered.	
(b) Please advise the type of critical illness suffered.	

(c) Answer the questions pertaining to your condition stated above.

(i) Are there any symptoms which are or were evident for this condition? If yes, please advise the date of onset of the symptoms.	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
(ii) Have you been recommended to receive or received treatment, advice or diagnosis for this condition? If yes, please advise the date of your 1st consultation.	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
(iii) Please describe the symptoms you experienced.									

(d) Please provide information on your first consultation.

Doctor Consulted			
Doctor's Address			
Doctor's Contact No.		Doctor's File Ref No. (If applicable)	

(e) Please provide information of your regular doctor.

Regular Doctor			
Regular Doctor's Address			
Regular Doctor's Contact No.		Doctor's File Ref No. (If applicable)	

(f) Please furnish the details of any hospitalisation in connection with this sickness.

Name of Hospital	Admission Date (DD-MM-YYYY)	Date Discharged (DD-MM-YYYY)	Admission No.	Type of Ward

(g) Have any of your family members experienced this similar or related sickness? If yes, please provide details.

Relationship of Family Member	Nature of sickness	Date Diagnosed (DD-MM-YYYY)	If Deceased, Date (DD-MM-YYYY)	Age

(h) Are there any other sickness/ complaints suffered by you prior to this event? If yes, please provide details.

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## Others

In respect of any other claim, which does not fall within the sections stated above, please provide details of the claim you are submitting. If the space is insufficient for such details, please attach another page.

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Date & Time of Accident	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="H"/> <input type="text" value="H"/> <input type="text" value=":"/> <input type="text" value="M"/> <input type="text" value="M"/>	<input type="text" value=""/> AM <input type="text" value=""/> PM
Claimed Amount			
Have you lodged a police report?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Report	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Police Station that you lodged report?			

**Details of your other Insurance or Compensation Claims**

Name of Insurer / Third Party	Policy/ Reference No.	Type of Benefit	Have you filed a claim?	Amount Claimed

NOTE: If the space provided is insufficient for your answer, please continue on a separate sheet.

Have your other claims been paid by the other policies above?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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**For Company / School / Kindergarten Use Only**

**Company Declaration (for Group Policy Only)**

I / We hereby certify that \_\_\_\_\_ is / my our employee effective from \_\_\_\_\_ and is currently holding the position of \_\_\_\_\_

If no longer under employment, please advise the last date of employment.

**School / Kindergarten Declaration**

I / We hereby certify that \_\_\_\_\_ is currently a student of my / our school / kindergarten.

Name/ Designation	
Date Signed	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Authorised signature of company / school/ kindergarten (Please also affix company / school kindergarten rubber stamp)	

## Payment Details

### Electronic Funds Transfer (Payment in SGD and to bank accounts in Singapore only)

Please provide details for the payment of this claim in the event that this claim is deemed payable by AIG. In such an event, this claim shall be payable to the relevant insured person only.

Payee Name (name as per bank account)					
Payee Address					
Name of Bank					
Bank Address					
Bank Code		Branch Code		Account No.	
Email address (if different from above)					

Notification of payment will be sent to this email address.

### Telegraphic Transfer (Payment in Overseas Currency for employment country-based out of Singapore)

Payee Name (name as per bank account)					
Payee Address					
Name of Bank					
Bank Address					
Bank Code		Branch Code		Account No.	
Swift Code		Bank Currency			
Email address (if different from above)					

Notification of payment will be sent to this email address.

## Important Notice

AIG shall (i) be discharged from all liability under this claim and (ii) not be liable for any and all losses incurred by you, as a result of you providing AIG with an inaccurate bank account number under this section for the payment of this claim.

## Acknowledgment and Declaration

I declare that to the best of my knowledge and belief that all the above information and particulars are complete, true and accurate and without reservation of any kind. If I made or shall make any false or fraudulent statements, or withhold material facts whatsoever in respect of this claim, the Policy shall be void and I shall forfeit all rights to recover therein. I agree to the conditions set out at the beginning of this claims form.

I authorise any hospital doctor, other person who attended or examined me, to furnish to AIG, and/ or its authorised representatives, any and all information relating to any illness or injury, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photocopy of this authorisation shall be considered as effective and valid as the original.

I authorise AIG to release any payment payable to me under this claim via electronic funds transfer to the bank account provided by me under the Payment Details section. I understand and acknowledge that AIG shall (i) be discharged from all liability under this claim and (ii) not be liable for any and all losses incurred by me, as a result of me providing AIG with an inaccurate bank account number under the Payment Details section for the payment of this claim.

In relation to the personal information collected in this claim form, I agree and consent, and if I am submitting information relating to another individual, I represent and warrant that I have the authority to provide that information to AIG, I have informed the individual about the purposes for which his / her personal information is collected, used and disclosed as well as the parties to whom such personal information may be disclosed by AIG, as set out in the contents of the consent clause below and the individual agrees and consents, that AIG may collect, use and process my/ his/ her personal information as follows:

- (a) the personal information collected in this form (or otherwise provided during the course of the claim process, including by way of call recordings) may be collected, used and disclosed by AIG to:
  - (i) process and administer this insurance claim;
  - (ii) assess, investigate, adjust and make a decision on this claim;
  - (iii) administer my insurance policy (including pursuing recovery from reinsurers or other parties);
  - (iv) deal with disputes and complaints,
  - (v) respond to requests for information from public and governmental / regulatory authorities, statutory boards and for audit, compliance, investigation and inspection purposes;
  - (vi) respond to requests from the policyholder;
  - (vii) carry out due diligence or other screening activities (including background check(s)) in accordance with legal or regulatory obligations or risk management procedures that may be required by law or that may have been put in place by AIG;
  - (viii) compliance with legal or regulatory obligations, risk management procedures and AIG internal policies;
  - (ix) manage AIG's infrastructure and business operations; and
  - (x) for other purposes stated in AIG's Data Privacy Policy.
- (b) AIG may transfer the personal information to the following classes of persons (whether located in Singapore or elsewhere) for the purposes identified in (a) above:
  - (i) third parties providing services related to the administration of my policy (including reinsurers) and processing of my claim;
  - (ii) AIG's agents;
  - (iii) brokers, my authorised agents or representatives or next-of-kin;
  - (iv) the policyholder;
  - (v) legal process participants and their advisors;
  - (vi) governmental/ regulatory authorities, industry associations, courts, other alternative dispute resolution forums;
  - (vii) other financial institutions for the purpose of administering this claim, obtaining policy payments;

- (viii) loss adjusters, assessors, third party administrators, emergency providers, legal services providers, retailers, medical providers and travel carriers, external auditors;
- (ix) another member of the AIG group (for all of the purposes slated in (a)) in any country; or
- (x) other parties referred to in AIG's Data Privacy Policy for the purposes stated therein.

Note: The full version of AIG's Data Privacy Policy can be found at [www.aig.sg/privacy](http://www.aig.sg/privacy).

Signature of Claimant:		Date Signed	<table border="1" style="display: inline-table;"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				
Signature of Policy Holder:		Date Signed	<table border="1" style="display: inline-table;"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				
Name		Designation									
Company/School Stamp											

## Accidental Death

Documents Required:

- Certified true copy of Death Certificate
- Autopsy report (where applicable)
- Police report for road traffic accidents or other accidents (where applicable)
- All relevant medical reports
- Police investigation report
- Coroner's inquiry (where applicable)
- Certified True Copy of Pay Slip
- Employment Contract
- When claiming for your spouse/ child(ren), please furnish copy of proof of relationship
- Copy of driver's license and certificate of auto insurance (where applicable)
- For industrial or work related accident: Work Injury Report lodged by the company.

## Permanent Disablement

Documents Required:

- Police report for road traffic accidents or other accidents (where applicable)
- All relevant medical reports
- Police investigation report
- Certified True Copy of Pay Slip
- Employment Contract
- Copy of driver's license and certificate of auto insurance (where applicable)
- For industrial or work related accident: Work Injury Report lodged by the company.

## Medical Expenses

Documents Required:

- Final medical invoice and receipts (as proof of payment)
- Police report for road traffic accidents or other accidents (where applicable)
- Medical Report/ Inpatient Discharge Summary/ Doctor's Memo/ Attending Physician's Statement (at Claimant/Guardian's expense)
- Doctor's prescription and Doctor's referral letter

## Temporary Disability

Documents Required:

- Medical Report / Inpatient Discharge Summary/ Doctor's Memo | Attending Physician's Statement (at Claimant / Guardian's expense)
- Medical Certificate
- Certified True Copy of Pay Slip
- Copy of driver's license and certificate of auto insurance (where applicable)
- For industrial or work related accident: Work Injury Report lodged by the company.

## Burn and Fracture

Documents Required:

- Radiological reports
- Medical report indicating type and location of fracture/degree of burns and percentage of burns
- Police report for road traffic accidents (where applicable)



American International Group, Inc. (AIG) is a leading global insurance organization. AIG member companies provide insurance solutions that help businesses and individuals in approximately 70 countries and jurisdictions protect their assets and manage risks. AIG common stock is listed on the New York Stock Exchange.

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CORPORATETRAVELINSURANCE2024APR

### Contact:

**AIG Asia Pacific Insurance Pte. Ltd.**  
**AIG Building**  
**78 Shenton Way #09-16**  
**Singapore 079120**