Berkshire Hathaway
Specialty Insurance

Work Injury Compensation Claim Form

The form must be completed truthfully and accurately. Please ensure all questions are answered and authorization duly completed by injured employee. Failure to comply with this requirement may prejudice any claim.

The acceptance of this Form is NOT an admission of liability on the part of Berkshire Hathaway Specialty Insurance Company ("BHSI"). Any documentary proof or report required by BHSI shall be furnished at the expense of the Policyholder or Claimant.

A. EMPLOYER

Policy No.:	Name of Policyholder:
Nature of Business:	Informant Name & Designation:
Address:	E-mail address:
Total number of Employees:	Contact Number:
Is your company GST registered? ☐ Yes ☐ No	GST Registration No:

Please provide your bank details to facilitate processing of payable and agreed medical expenses and medical leave wages.

Bank Account Holder Name:	Branch Code:
Name of Bank:	Bank Code:
Account Number:	Swift Code:

B. INJURED EMPLOYEE DETAILS

Copy of Work Permit/Employment Pass/Passport (for Foreigner Employee)/NRIC is required

Name of Injured Employee:	Occupation of the Injured Employee:
Nationality: (please provide social security number (SSN) for Us Citizen)	General description of Injured Employee's scope of work:
Work Permit/Employment Pass/NRIC No:	Gender/Race/Age:
Marital Status:	Mobile Number of Injured Employee:
No. of children/dependants:	Residential Address in Singapore of Injured Employee
Was the Injured Employee engaged in the employment of Policyholder at time of accident? ☐ Yes ☐ No If no, please provide details:	
No. of days worked per week by Injured Employee:	Email Address of Injured Employee:

Please provide the following information and copies of salary vouchers paid during last 12 months.

Month	No. of working days	Gross monthly earnings (excluding bonus)	Annual wage supplement / bonus paid during last 12 months
TOTAL			
MONTHLY AVERAGE			

Please provide injured employee's bank details to facilitate processing payable and agreed permanent incapacity compensation (if any).

Bank Account Holder Name:	Branch Code:
Name of Bank:	Bank Code:
Account Number:	Swift Code:

C. ACCIDENT DETAILS

Date & Time of accident:	Location of accident:
Describe exactly how the accident happened: (Please attach a copy of police report if one has been lodged)	
Who is the party who caused/contributed to the accident?	
Is there any witness to the accident? ☐ Yes ☐ No If yes, please provide name, contact details and address of:	
Was any person involved in the accident under the influence of liquor/drugs? ☐ Yes ☐ No If yes, please provide details:	
Was the Injured Employee in your direct employment? ☐ Yes ☐ No If no, state clearly if the injured employee is casual or permanent or temporary loan to you? ____________________ If on loan, from whom? Name: ____________________ Address: ____________________	

Did the Injured Employee comply with safety regulations? If no, please provide details:	☐ Yes	☐ No
Did the Injured Employee attend any safety precaution briefing? If yes, please provide date and nature of last attended briefing:	☐ Yes	☐ No
Was the Injured Employee guilty of any misconduct or violation of rules and/or orders? (i.e. was the injured employee wearing safety boots or safety harness etc.?) If yes, please provide details:	☐ Yes	☐ No
Was there any investigation conducted after the accident? If yes, please provide a copy of the investigation report.	☐ Yes	☐ No

D. INJURY DETAILS

Please advise whether the Injured Employee had any previous injury under your employment? If yes, please provide details:	☐ Yes	☐ No
(a) Are there any pre-existing conditions when he was employed? If yes, please provide details:	☐ Yes	☐ No
(b) Would such physical defect or infirmity have contributed towards this accident?	☐ Yes	☐ No
(c) Was the Injured Employee's injuries affected by any pre-existing condition before the accident? If yes, please provide details:	☐ Yes	☐ No
State the nature and extent of injuries (i.e. fracture of hand, amputation of toe, sprain to back etc.)		
State the region of injured part:		
Was the Injured Employee hospitalized? If yes, please provide name of hospital or a copy of inpatient discharge summary.	☐ Yes	☐ No
Did the Injured Employee attend any outpatient treatment after the accident? If yes, please provide name of hospital or clinic:	☐ Yes	☐ No
How many days of Medical Leave was Injured Employee given from time of accident? (a) Hospitalization Leave:________________ (b) Outpatient Leave:________________		
Has the Injured Employee returned to work? If yes, please advise date of return: If no, please advise date that injured employee is on Medical Leave:	☐ Yes	☐ No
Is the Injured Employee able to do partial work?	☐ Yes	☐ No
Was the Injured person performing work on a contract/project undertaken by you? If yes, from whom? Name: ________________ Address:________________	☐ Yes	☐ No
If above is Yes, please provide the name and address of the main contractor of the contract/project: Name: ________________ Address:________________		

COMPULSORY – (TO BE COMPLETED BY THE INJURED EMPLOYEE)

RELEASE AND DISCLOSURE OF MEDICAL INFORMATION

For the purposes of this authorization, a reference to BHSI includes its related group of companies, service providers, representatives and agents.

For the purposes of policy administration, customer services, claims handling and fraud analysis and prevention, including but not limited to whether BHSI decides to insure or continue to insure me for my insurance applications or policies, I hereby authorize any hospital, doctor, physician, clinic and any other healthcare practitioner or provider who has attended to or examined me for any reason to:

a) disclose to BHSI any and all information with respect to my injury, illness, sickness, treatment, medical history and/or consultation (whether the subject of this claim or otherwise), and such other personal data as BHSI in its sole and absolute discretion considers relevant for its assessment of this claim; and

b) provide to BHSI a copy of any medical reports and/or hospital/clinical records arising from or associated with any such injury, illness, sickness, treatment, medical history and/or consultation.

I hereby authorize BHSI to disclose my personal data (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.

A photocopy of this authorization shall be as effective and valid as the original.

Name of Injured Employee:	Work Permit/Employment Pass/NRIC No:
Signature of Injured Employee:	Date:

DECLARATION

I/We declare that I/we have complied with the conditions and warranties (if any) of the policy and in no manner deliberately caused the said loss or damage or sought unjustly to benefit thereby by any fraud or wilful misrepresentation and that the information shown on this form is true and that I/we have not concealed any information relating to this claim. I/We agree to the conditions set out at the beginning of this claim form.

I/We, HEREBY DECLARE that the above statements and particulars are true and correct in every respect and are made without reservation of any kind. I/We agree that if I/we have made any false or fraudulent statements or suppress, conceal or falsely state any material facts whatsoever, either now, or in the future, with regard to this claim, the relevant policy shall be void and all rights of recovery in respect of past or future claims, shall be forfeited.

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

(a) the personal data collected in this form (or otherwise provided during the course of the claim process) may be collected, used and disclosed by BHSI to:

(i) process and administer this claim;
(ii) assess, investigate, adjust and make a decision on this claim;
(iii) administer my/his/her insurance policy and exercise the rights of BHSI under my/his/her insurance policy (including pursuing recovery from reinsurers or other parties);
(iv) process requests for payment, and for direct debit authorization;
(v) deal with disputes and complaints;
(vi) respond to requests for information from public and governmental/regulatory authorities, statutory boards and for audit, compliance, investigation and inspection purposes;
(vii) respond to requests from the policyholder;
(viii) carry out identity, membership, background and/or information checks 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 BHSI;
(ix) compliance with legal and/or regulatory obligations, risk management procedures and BHSI internal policies;
(x) manage BHSI infrastructure and business operations; and
(xi) for other purposes stated in BHSI Data Privacy Policy.

(b) BHSI may transfer my/his/her personal data 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/his/her policy (including reinsurers, claim investigation companies, industry associations/federations, suppliers or intermediaries) and processing of this claim;
(ii) BHSI agents and brokers;
(iii) my/his/her authorized 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 and/or obtaining policy payments;
(viii) loss adjustors, assessors, third party administrators, emergency providers, legal services providers, retailers, medical providers, travel carriers and external auditors;
(ix) another member of the BHSI group (for all of the purposes stated in (a)) whether in Singapore or anywhere else in the world; and/or
(x) other parties referred to in BHSI Data Privacy Policy for the purposes stated therein.

Note: The full version of BHSI Data Privacy Policy can be found at www.bhspecialty.com.

I/We further authorize any individual or entity holding any records including any statements taken or knowledge of me/us which is/are relevant to the settling of this claim and/or the insurer's right of recovery hereunder to furnish such records or knowledge to BHSI or its authorized representatives. A photocopy of this authorization shall be considered as effective and valid as the original.

____________________ Date

____________________________________ Signature of Policyholder & Company Stamp
Name of Authorized Employee