Please mail the claim documents to:
AVA INSURANCE BROKERS PTE LTD
91 Bencoolen Street
#08-03 Sunshine Plaza
Singapore 189652

GROUP PERSONAL ACCIDENT CLAIM FORM
(STUDENT PROTECTION PLAN)

Policy No.	

IMPORTANT NOTICE
The acceptance of this form is not an admission of liability. It should be completed as fully and accurately as possible and returned immediately.
If the claim is found to be fraudulent, or if any fraudulent means are used to obtain any benefit under this policy, the policy will be rendered void.

PARTICULARS OF INSURED		
Name of Insured / Name of School:		
PARTICULARS OF CLAIMANT		
Name of Claimant:	NRIC / Passport No:	
Name of Parent / Legal Guardian:	NRIC / Passport No:	Contact no.:
Postal Address:		
CHEQUE PAYEE NAME *(for Cheque Claims Processing)*		
Name of Cheque Payee:		
ACCIDENT DETAILS		
Date & Time of Accident:	Place of Accident:	
Describe the full circumstances of the accident and the nature of injuries sustained:		
Please provide: *a) Original medical bills and/or medical reports/memo from the attending doctor stating the nature of injury if you are treated as an outpatient as a result of an accident;* *b) Original hospital final bill and inpatient discharge summary/medical report if you are hospitalized as a result of an accident.*		
NATURE OF CLAIM *(I am making a claim under the following sections)*		
☐ Accidental Death	☐ Permanent Disablement	☐ Accidental Medical Expenses ☐ Hospital Cash Benefit

I declare that to the best of my knowledge and belief that the above particulars are true and accurate. 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 the benefits therein. I authorise any hospital doctor, other person who has attended to or examined me, to provide to the Insurance Company, and/or its authorised representatives, with any and all information relating to my medical conditions, illness, 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 further declare that the information provided in this claim form or held by Great American Insurance Company, Singapore Branch whether contained in my/our insurance application or otherwise obtained may be used and disclosed to your employee, authorised representative and/or companies or any independent third parties (within or outside Singapore) who will provide claims administrative, advice and/or information of claims services in relation to my/our claim. I/We understand that my/our data may also be used for the purpose of audit, business analysis and reinsurance. My/Our signature provided hereunder shall signify this consent.

Notice of Personal Data Protection Policy
By Signing this form
(a) I/We acknowledge and give consent to Great American Insurance Company in collecting using, processing and disclosing to third party service providers and/or intermediaries, within or outside Singapore, my/our personal data for the purpose of processing and servicing my/our policies/claims;
(b) I/We declare and confirm that I/We have obtained the consent of the person(s) and /or nominee(s) named herein, where applicable, and that he/she/they has/have authorized me/us to disclose their personal data and to give consent on their behalf for the above collection, use, process and disclosure; and
(c) I/We acknowledge the detailed Privacy Policy Statement, governing the above, posted at
http://greatamericaninsurancegroup.com/insurance/Singapore-Branch/Document/SGP-Privacy-Policy-for-Website

Signature of claimant & Date

Authorised Signature & Company stamp of Policyholder & Date

GREAT AMERICAN INSURANCE COMPANY

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(ONLY APPLICABLE FOR ACCIDENTAL MEDICAL CLAIM ABOVE S$1,000)

MEDICAL REPORT – TO BE COMPLETED BY ATTENDING PHYSICIAN

Name of Patient:	NRIC / Passport No:

Are you the patient's usual medical doctor? ☐ Yes ☐ No

Have you attended him/her for any illness or accident before? ☐ Yes ☐ No

If yes, state for what and when _____

Is condition due to ☐ Sickness ☐ Injury ?

After the accident, the first treatment was 1) When? _____ 2) Where? _____

Was patient in your opinion, perfectly sober at the time of accident? ☐ Yes ☐ No

State as fully as possible the diagnosis of the illness/the nature and extent of injuries sustained:

_____

_____

Are the injuries on the right or left side? _____

In your opinion, are the injuries sustained in line with the accident that patient describe? ☐ Yes ☐ No

Is the patient now or was he/she at the time of accident, suffering from or affected? ☐ Yes ☐ No
by any physical infirmity, disease, or illness, irrespective of injuries?

If yes, 1) state nature _____
2) extent it impede the recovery of patient _____

Is patient suffering from or does he/she suffered from any cardiac affection, gout, rheumatism, or fits of any kind? ☐ Yes ☐ No

Are you aware of anything in the previous medical history of the patient which might have contributed directly or indirectly, to the occurrence of the accident, or which may be likely in any what to retard his/her recovery from it?

_____

Whether the injuries sustained will result in any permanent disablement/incapacity. If so, please advise percentage of disablement/incapacity.

I hereby certified that I have personally examined and treated the patient for the above illness / injuries and that the facts as given above present my opinion of the patient's condition:

Signature of Physician / Surgeon : _____ Date: _____

Name & Designation :

_____

Name & address of clinic / hospital: _____