



**ace insurance**

ACE Insurance Limited

Co Regn No: 199702449H

600 North Bridge Road #04-02 Parkview Square Singapore 188778

Tel: 65-6398 8000 Fax: 65-6293 4058

**EZ-LINK CLAIM FORM**

The acceptance of this Form is NOT an admission of liability on the part of the Company.

**SECTION (A) : PARTICULARS OF INSURED**

Name & Address of Insured:	Policy No.:	Period of Insurance:
	E-mail Address (office):	E-mail Address (Personal):
	Tel. No. (Residence & Office):	Tel. No. (Mobile):
	Date of Birth:	Occupation:
	I/C No. / Passport No.:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female

**SECTION (B) : PARTICULARS OF LOSS OR OCCURRENCE**

Explain exactly on how did the loss occur:	Country of occurrence: <input type="checkbox"/> Singapore <input type="checkbox"/> Malaysia <input type="checkbox"/> Others: _____		
	Place of loss or occurrence:		
	Date of loss:	Time of loss:	
	On when and by whom was the loss discovered:	Relationship:	
	Name & Address of any witnesses of the Incident:	NRIC/Passport:	
		Telephone No.:	

**SECTION (C) : POLICE REPORT**

Were particulars of loss or particulars taken by or reported to the Police <input type="checkbox"/> Yes <input type="checkbox"/> No	<p><b>If yes,</b> (a) Please specify name of Police Station:</p>   <p>(b) Attach a copy Police Report/Statement.</p> <p>N.B. The Police must be informed immediately if the property has been lost or maliciously damaged.</p>
--	---

**SECTION (D) : LOSS OF PERSONAL EFFECTS / EZ-LINK CARD**

(Please furnish relevant Report from relevant authorities AND original purchase receipts)

Give details of amount claimed

DESCRIPTION OF ITEM (include Activation date of EZ-Link Season Pass)	WHEN AND WHERE PURCHASED	ORIGINAL PURCHASE PRICE	AMOUNT RECOVERED FROM OTHER SOURCES	AMOUNT CLAIMED

*(Please use supplementary sheet if necessary)*

**SECTION (E) : PERSONAL ACCIDENT – MEDICAL EXPENSE**

(Please attach original medical receipts)

Please state the type of Diagnosis:  Have you ever suffered similar medical condition or is this medical condition related to a previous injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	If <b>yes</b> , please specify dates & circumstances of similar medical condition or previous injury and name & address of the doctor concerned:		
AMOUNT PAID BY YOU:	AMOUNT RECOVERED FROM OTHER SOURCES:	AMOUNT CLAIMED:	

**SECTION (F) : ANY OTHER INSURANCES**

Are there any other Policies of insurance in force covering you in respect of this event?     Yes       No

If **yes**, please specify below:

NAME & ADDRESS OF INSURANCE COMPANY(S)	POLICY NO(S).

**SECTION (G) : CLAIMS HISTORY**

Have you or any insured person previously sustained loss/damage or caused damage/injury to third parties?     Yes       No

If **yes**, please specify below:

NAME OF INSURER	CLAIM NO.	DATE OF LOSS	NATURE OF LOSS	AMOUNT PAID
<i>(Please use supplementary sheet if necessary)</i>				

(1) I/We do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and \*I/We agree that if \*I/We have made or in any further declaration in respect of the said claim shall make any false or fraudulent statements of suppress conceal or falsely state any material fact whatsoever the Policy shall be void and all rights to recover thereunder in respect of past or future claims shall be forfeited.

(2) I/We hereby authorize any hospital physician, other person who has attended or examined me, to furnish to the company, or its authorized representatives, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

(3) I/We hereby authorize and request ACE Insurance Ltd to pay benefit due in respect of this claim to : \_\_\_\_\_  
(Name As Per Identification Card and/or Bank Account)

Claimant's Signature : \_\_\_\_\_ Insured's Signature : \_\_\_\_\_ Date : \_\_\_\_\_

(see note below)

Note: If (a) The Insured is claiming on his own belief or (b) the Claimant concerned is a Child under 18 years of age – only the Insured's signature is required.