



A. Details of Policy Holder/ Migrant Domestic Helper

Policy Number Name of Employer (as stated in NRIC/FIN)

Address Postal code

NRIC/FIN: Tel: Email:

Helper's Name: Wages/month \$ Levy/month \$

Helper's FIN: Please attach a soft copy Helper's Work Permit/Passport for verification.

Employment agency address and contact:

B. Details of Accident / Sickness leading to this Claim

Please State date/ Time Date Sickness first occurred

Location of accident Date Sickness First treated

Please State exactly what happened (Symptoms of illness/ Nature of injury (Where necessary Include statements))

We may request for a Medical Report (Completed by attending Physician) if more information on the medical condition is required.

Was a Police Report made? Yes No

Was there any action taken against you by the ministry of manpower? Yes No

Are there any other insurance policies covering you for this loss/accident/injury? Yes No

If Yes to the above please give details

C. Payment Mode/Details

Paynow (Preferred) Please Provide Employer's NRIC/FIN: (Please provide copy of NRIC/Singpass Digital copy for verification)

Note: Mobile no registered PayNow is not accepted) Please ensure you are registered for PayNow with your NRIC/FIN NO

Or

Bank Transfer Bank Name: Bank Account Number:

Note: Please provide supporting documents such as section of bank statement which shows bank details for verification of payee details. If payee is different from claimant or is not listed in the policy please provide a Letter of Authorisation.

Email: Please provide employer's email for bank processing confirmation.

Important Notice: Tokio Marine Insurance Singapore Ltd ("TMIS") does not admit liability by the issuance of this form. Please fill in the sections on General Information & the relevant sections that you want to claim. Please send the duly signed form to the above listed address marked for the attention of Fire and GA Claims Department. Email: tmsclaims@tokiomarine.com.sg

Declaration: I hereby declare and warrant that all the answers given above to be true. I accept that insurers would be at liberty to deny liability in part or in full if the above written answers are false or inaccurate in any aspect.
Notice for Personal Data Protection Policy

By signing this Form:

- i. I/We acknowledge and consent to TMIS collecting, using, processing and disclosing to third party service providers, or intermediaries, within or outside Singapore, my/our personal data for the purpose of processing/servicing my/our policies/claims;
- ii. 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
- iii. I/We acknowledge the detailed Privacy Policy Statement, governing the above, posted at <http://www.tokiomarine.com/sg>.

Employer Name:		Migrant Domestic Helper Name:	
Signature of policy Holder	Signature of Migrant Domestic Helper		
Date (dd/mm/yyyy)		Date (dd/mm/yyyy)	



Policy Coverage and Documents Required (Checklist)

The Sections Below are covered only if it is shown in the schedule. Clarifications will be sought as necessary if documents are incomplete/ Unclear

<input type="checkbox"/>	<p>Section 1 Personal Accident</p> <p>(A) Accidental Death of Permanent Disablement</p> <p>(B) Outpatient Medical Expenses for Accidents</p>	<ul style="list-style-type: none"> • Police Report / Death Certificate as applicable • Original medical Bills • Investigation reports as applicable
<input type="checkbox"/>	<p>Section 2 Hospital and Surgical Expenses</p> <p>1) Date admitted <input type="text"/></p> <p>2) Date discharged <input type="text"/></p> <p>3) Date surgery performed <input type="text"/></p>	<ul style="list-style-type: none"> • Finalised hospital bill (original) • Medical Report (or Memo)/ Inpatient Discharge Summary • Day Surgery Discharge Summary/ Authorisation form • Investigation reports as applicable <p>Is the sickness due to pregnancy, abortion, sterilisation or infertility?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable</p>
<p>If yes, please specify condition & approximate date of commencement?</p>		
<p> </p>		
<input type="checkbox"/>	<p>Section 3 (Wages and Levy Compensation)</p> <p>Section 4 (Recuperation Benefit) Payable to domestic helper</p> <p>Section 5 (Temporary Domestic Help Benefit) (Applicable for hospital and surgical Claims 3(B) Section 2)</p>	<ul style="list-style-type: none"> • Finalised hospital bill (original) • Levy Statement <p>No of Days Hospitalised <input type="text"/></p>
<input type="checkbox"/>	<p>Section 6 (Termination and Re-Hiring Expenses)</p> <p>(Subject to prior agreement obtained from insurer and replacement within 90 days of termination)</p>	<ul style="list-style-type: none"> • Medical report or memo from a medical practitioner certifying that the disablement, injury or illness prevents domestic helper from carrying out her duties as a foreign domestic worker.
<input type="checkbox"/>	<p>Section 7 (Repatriation Expenses)</p> <p>Burial / Cremation /Return of body/Transport expense</p>	<ul style="list-style-type: none"> • Invoice and proof of payment



Maid Protector Plus Claim Form

<input type="checkbox"/>	<p>Section 8 (Dread Diseases) Claim Amount (payable to domestic helper) Please state clearly the dread disease diagnosed</p>	<ul style="list-style-type: none"> • Medical Report (or Memo)/ Inpatient Discharge Summary • Investigation reports as applicable
<input type="checkbox"/>	<p>Section 9 (Special Grant) Claim Amount (payable to domestic helper's estate or her legal personal representative)</p>	<ul style="list-style-type: none"> • Police Report / Death Certificate as applicable • Medical Report (or Memo) as applicable • Investigation reports as applicable • Proof of relationship to the person who died
<input type="checkbox"/>	<p>Section 10 (Domestic Helper's Liability)</p>	<ul style="list-style-type: none"> • Demand Letter from third party • Police Report/Investigation Report as applicable • Detailed description of incident and photographs
<input type="checkbox"/>	<p>Section 11 (Fidelity Guarantee)</p>	<ul style="list-style-type: none"> • Proof of Amount Claimed • Police Report/Investigation Report as applicable • Detailed description of incident / photographs • Witness names
<input type="checkbox"/>	<p>Section 12 (Domestic Helper's Belongings)</p>	<ul style="list-style-type: none"> • Proof of amount claimed • Police report/Investigation Report as applicable • Detailed description of incident / Photographs • Witness names



Tokio Marine Maid Protector Plus Letter of Authorization for Payment to Hospitals

To Medical Superintendent:

I, **(A) Name of Employer** of **(B) NRIC/FIN** hereby authorize **Tokio Marine Insurance Singapore Ltd** to act on my behalf, to settle the claims of **(C) Name of Migrant Domestic Helper** of **(D) Work Permit Number's** medical expenses incurred on **(E) Hospitalization on Date**, this involves payment for specific or related bills from the hospital.

(A) Name of Employer:		
(B) NRIC/FIN:		
(C) Name of Migrant Domestic Helper:		
(D) Work Permit Number:		
(E) Hospitalization Date:		
Invoice no:		
Date of Final Invoice:		
Name of Hospital:		
Policy Number:		
25% Co-payment Applicable:	Yes	No

I understand and agree that if a claim is admissible Tokio Marine Insurance Singapore Ltd will settle the bill in the following manner:

- If Co-payment is not applicable in the policy, admissible claims will be fully settled by Tokio Marine Insurance Singapore Ltd up to the policy limit stated in the schedule.
- Where Co-Payment is applicable the first S\$15,000.00 of admissible claims will be fully settled by Tokio Marine Insurance Singapore Ltd.
 - Where applicable admissible claims exceeding S\$15,000.00 will be settled after deducting a 25% Co-Insurance portion as stated in the policy.
 - Where applicable I accept my obligation to settle the 25% Co-payment amount.
- I accept my obligation to settle the expenses outside the scope of coverage provided by Tokio Marine Insurance Singapore Ltd.

(Employer's/Claimant's Signature)

Date (dd/mm/yyyy)_____