



# MOTOR INSURERS' BUREAU OF SINGAPORE

180 Cecil Street #15-02 Bangkok Bank Building Singapore 069546 Tel: 62208607/62205947 Fax: 62278764  
Co. Reg. No. 197500151Z

## APPLICATION FORM

**(The Issue and Acceptance of this form is not an admission of liability on the part of MIB)**

### **A. INFORMATION ON THE DECEASED (if applicable)**

Name (as appearing in I/C) \_\_\_\_\_

Correspondence Address \_\_\_\_\_

Identity Card No./ Passport No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Sex \_\_\_\_\_ Nationality \_\_\_\_\_ Marital Status \_\_\_\_\_

Name of Present Employer \_\_\_\_\_

Address \_\_\_\_\_

Occupation \_\_\_\_\_ Monthly Income \_\_\_\_\_

### **B. INFORMATION ON THE APPLICANT**

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone No \_\_\_\_\_

Identity Card No./ Passport No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Sex \_\_\_\_\_ Nationality \_\_\_\_\_ Marital Status \_\_\_\_\_

Name of Present Employer \_\_\_\_\_

Address \_\_\_\_\_

Occupation \_\_\_\_\_ Monthly Income \_\_\_\_\_

### **C. DETAILS ON DEPENDANTS OF THE INJURED APPLICANT/DECEASED, if applicable**

Name of Dependants & Relationship to the Injured Applicant/Deceased	Age	Sex	Name and Address of Employer	Occupation	Monthly Income

**D. DETAILS OF ACCIDENT**

Date	Day of Week	Time (am/pm)	Indicate Condition at Time of Accident	
			Weather : <input type="checkbox"/> Dry	<input type="checkbox"/> Raining
			Road : <input type="checkbox"/> Dry	<input type="checkbox"/> Wet

**E. DESCRIPTION OF ACCIDENT - To describe how the accident occurred**

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**F. INFORMATION OF ALL VEHICLES INVOLVED, including vehicle the Applicant was in/on**

	(a)	(b)	(c)
Vehicle No:			
Name of Owner:			
Address:			
Name of Driver/Rider:			
Address:			
Contact No.:			
Insurer:			

**G. RESPONSIBILITY (Who do you consider to be blamed and why)**

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If application is based on the allegation that the driver of the other motor vehicle/s was negligent, please attach statement duly signed by the Applicant setting out the facts relied on by him/her for the allegation.

**H. SKETCH PLAN OF ACCIDENT** - Please show Street Names and road signs/important physical features (Please number each Vehicle and show direction of travel by arrow).

**I. POLICE REPORT/S**

(Attach copies of Police Investigation Result and all Police Report/s made by the Applicant and Witness/es)

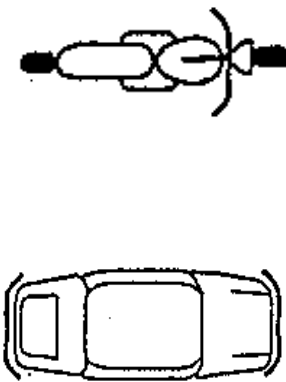
- (a) Police station where the Applicant's report was made \_\_\_\_\_ (b) Police Report No \_\_\_\_\_
- (c) Date of Report \_\_\_\_\_ (d) Name of Police Investigating Officer \_\_\_\_\_
- (e) Action taken by police against parties involved \_\_\_\_\_
- (f) To give details of any Prosecution/Intended Prosecution \_\_\_\_\_

**J. WITNESS/ES, if any: (Attach Statements made by Witness/es to be under Statutory Declaration or Affidavit)**

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Age \_\_\_\_\_ Identity Card No. \_\_\_\_\_ Sex  Male  Female

**K. CLAIM CLASSIFICATION**

**(a) Uninsured Vehicle**

Vehicle	Mark Area of Impact/ Damage	Driver	Owner
Vehicle No:		Name:	Name:
List name of parts damaged:			
		Address:	Address:
Make:			
Model:		NRIC No.:	NRIC No.:
Color:			
Name of Insurer:		Tel No.:	Tel No.:

**(b) Untraced Vehicle**

Description of Untraced Vehicle	Description of Untraced Driver, if applicable
Make: _____ Model: _____ Colour: _____ Type: (Bus / Car / Lorry / Motorcycle / Van / Taxi ) Additional Info: _____ _____	

**L. INJURY SUSTAINED BY THE APPLICANT AND QUANTUM OF CLAIM**

(Itemise and state amount under each item supported by Legal Authorities and Medical / Hospital /Specialist Reports).

Injuries Sustained	Claim Amount	Legal Authorities

**M. INFORMATION ON PREVIOUS ACCIDENT/S**

Date of Accident	Type of Accident	Injury Sustained & Disabilities

**N. INFORMATION ON OTHER CLAIMS FOR PERSONAL INJURY**

	<u>Date Paid</u>	<u>Amount Paid S(\$)</u>
(a) Personal Accident	_____	_____
(b) Hospitalisation & Surgical	_____	_____
(c) Workmen's Compensation	_____	_____

**A. DECLARATION**

- 1) I declare that I have not and will not be receiving any payment under any policy which afford a similar indemnity for this claim and also that no claim has been lodged against me in relation to this accident.
- 2) I declare that I am the person referred to in this claim and to the best of my knowledge, the information provided is true and complete. If required I undertake to give further assistance to the Motor Insurers' Bureau (MIB).
- 3) I authorise the release of all information to the MIB or its representatives from any sources, which will be relevant to my claim for compensation.
- 4) I recognise that if I provide MIB with false information, I will be liable to prosecution and my claim will not be paid. In addition MIB may seek to recover from me the costs of processing my claim.

**B. DATA PRIVACY STATEMENT**

In accordance with the Personal Data Protection Act 2012, I/We consent to the collection, use, disclosure of and/or process my/our personal data (whether contained in this Application Form or otherwise obtained) by the Motor Insurers' Bureau of Singapore, its affiliates and service providers (within or outside Singapore), the relevant government authorities/agency, for the purpose/s relating to the evaluation and processing of the claim submitted and to provide advice and information relating to the claim to me/us by Mail, Email and fax messages (notwithstanding the registration of my/our telephone number(s) in the Singapore's Do Not Call Registry).

Yes, I/We have read and agreed to the above Data Privacy Statement.

Signature of Applicant .....

Name \_\_\_\_\_

NRIC/Passport No. \_\_\_\_\_

Date \_\_\_\_\_

.....  
Signature of Solicitor  
**With Firm's Rubber Stamp**

\_\_\_\_\_  
Name of Solicitor

\_\_\_\_\_  
Date