



Occupational Safety and Health Division

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**APPLICATION FORM FOR WORK INJURY COMPENSATION CLAIM
UNDER THE WORK INJURY COMPENSATION ACT**

INSTRUCTIONS:

This application form is to be used for claiming compensation under the Work Injury Compensation Act. It is to be completed by the injured employee.

To complete this form, you will require the date of accident and the particulars of the injured employee and employer.

It will take about 5 minutes to complete this form.



APPLICATION FORM FOR WORK INJURY COMPENSATION CLAIM UNDER THE WORK INJURY COMPENSATION ACT

Important Notes on Claiming Compensation under the Work Injury Compensation Act (WICA):

1. Any claim for work injury compensation has to be submitted to the Ministry within **one year** from the date of the accident, failing which you will lose your right to claim the compensation under the WICA, if any, unless the failure to lodge a claim is occasioned by mistake, absence from Singapore or other reasonable cause.
2. After you have submitted your claim for compensation under the WICA to the Ministry, **you are required to inform the Ministry of any change in your contact address, failing which your claim may be suspended and no compensation will be payable to you.**
3. You will need to withdraw your WICA claim in writing before you can file a civil suit. Where a Notice of Assessment of compensation has been issued in respect to your claim under the WICA, you will need to withdraw this claim by the 28th day after the date of service of that Notice in order to file a civil suit.
4. If you wish to claim under the WICA again after having withdrawn your claim, you will need to submit to the Ministry a fresh application for compensation under the WICA.

SECTION A – DETAILS OF ACCIDENT

Date of Accident: _____

Name of Employer: _____

SECTION B – APPLICATION FOR WORK INJURY COMPENSATION

(Please tick one. If no box is ticked, you would be deemed to have ticked Option a)

a) I wish to claim compensation for injuries sustained in the above-mentioned accident under the Work Injury Compensation Act;

OR

b) I do not wish to claim compensation for injuries sustained in the above-mentioned accident under the Work Injury Compensation Act (Please refer to the Important Notes above).

SECTION C – PARTICULARS OF INJURED EMPLOYEE

Name: (as in identity card/ passport)	Average monthly earnings:
NRIC No. (for Singaporeans only) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Foreign Identification No. (FIN) (for foreigners only) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Passport/Travel Document <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date of Birth <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> D D M M Y Y Y Y	Nationality:
Occupation:	Commencement Date of Employment <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> D D M M Y Y Y Y
Mailing / Contact Address: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Blk / Hse No Floor No. Unit No. Postal Code Building Name : _____ Street Name : _____	
Foreign Address: (as in passport) (To be completed by all foreign employees)	
Contact No:	Email Address:
Signature/ Thumbprint of Injured Employee:	Date: