United Overseas Insurance Limited

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Co. Reg. No. 197100152R

CLAIM FORM – PERSONAL ACCIDENT INSURANCE

This form is issued without prejudice to any of the stipulations or conditions of the Company's Policy, and is not to be taken as an admission of liability on the part of the Company.

This form should be completed and returned within SEVEN (7) days of its receipt by the Insured.

IT IS ESSENTIAL THAT EACH QUESTION SHOULD BE ANSWERED AS FULLY AND ACCURATELY AS POSSIBLE

PARTICULARS OF INSURED

Insured : _____

Address : _____

_____

Singapore _____

Date of payment of last premium : _____

Insured Person : _____

Date of Birth : _____

Policy Number : _____

Contact Number : _____

Email : _____

Date of Incident : _____

1.	(a) How did the Accident happen? (b) What were you doing at the time?	
2.	What injuries have you sustained?	
3.	Has the same part been injured previously?	
4.	How long have you been totally or partially disabled from engaging in or attending to your usual business as a result of the injuries?	Totally From _____ To _____ Partially From _____ To _____

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5.	(a) How long were you or will you be continuously totally disabled (unable to work)? (b) How long were, or will you be partially disabled?	(a) From _____ To _____ (b) From _____ To _____
6.	Name and address of Doctor who attended to you Is he your usual Doctor?	
7.	Name and addresses of any witnesses of the Accident	
8.	Are you claiming under any other insurance? If so, please provide the following details: (a) Name of Insurance Company (b) Policy number (c) Amount of benefits (d) Date of insurance	

Important Notice

In accordance to the provisions of the Personal Data Protection Act 2012 ("PDPA"), the UOI's privacy notice shall form part of the terms and conditions of the Policy. A copy of UOI's Privacy Notice can be found at www.uoi.com.sg

Declaration

I/We declare that the information given in this claim form is true and correct to the best of my knowledge and belief. I/We undertake to render every assistance on my/our power in dealing with the matter.

_____ _____

Name and Signature of Insured Date

_____

Company's stamp (if applicable)