United Overseas Insurance Limited

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Singapore 068909
Tel (65) 6222 7733
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uoi.com.sg

Co. Reg. No. 197100152R

CLAIM FORM

The Insured is requested to state as fully and accurately as possible the information asked for hereunder and to return this form immediately to United Overseas Insurance Limited. The acceptance of this form is not in itself an admission of liability on the part of the Company. We reserve our right to request from you any additional information / documentation.

Policyholder Information		
Policy Number	Name of Insured	NRIC/ Passport Number
Address	Email	Tel No. (Mobile/ Home/ Office)
Gender	Occupation and Name of Employer	

Clamiant Information (if different from the Policyholder)		
Policy Number	Name of Insured	NRIC/ Passport Number
Address	Email	Tel No. (Mobile/ Home/ Office)
Gender	Occupation and Name of Employer	

1	(a) For Accident / Injury: Date, time and place of accident / injury and full description on how it happened.	
	(a) (i) Is this a job-related accident? Yes / No. If yes, are you compensated by your employer. Please submit copy of your compensation letter from your employer.	
	(b) For Sickness / Illness :- Please state full description of sickness / illness from which you are now having.	
	(b) (i) For Sickness / Illness :- - Date Symptoms first started - Date First Treatment - Place you sought treatment	
2	If you had a history of similar accident / sickness / illness which you have experienced in the past, please give details as to when, where and from whom you received medical diagnosis, treatment, consultation or prescribed drugs.	
3	Name and address of Hospital and doctor(s) who treated you and consultation date(s).	

Member of the UOB Group

4	How long have you been totally or partially disabled from engaging in or attending to your usual business as the result of the injuries or sickness?			
5	Name and address of any witness of the Accident / Injury			
6	Are you making any other insurance or compensation claim as a result of this injury or sickness? Yes/ No? If yes, please state below:			
	Name of Insurance Company	Policy No.	Amount of Benefits	Date of Insurance Effected

Supporting Documents to submit: Hospital / Medical Invoice, Discharge Summary/ Doctor's Note.

We reserve the right to request for further information / documents we deem necessary for our review of your claim.

DIRECT CREDIT CLAIM PAYMENT TO MY ACCOUNT -

Name of Bank (SG Account Only)	Bank Account Holder Name	Bank Account Number

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.

I, the undersigned, do hereby declare that to the best of my knowledge and belief, the foregoing particulars are true and correct. I understand that any false or fraudulent statements or any attempt to suppress or conceal any material facts shall render the policy void and the Insurer may refuse to pay the claim.
I hereby authorize any hospital doctor or other people who has attended to me to furnish United Overseas Insurance Limited or its representatives any and all information with respect to any sickness, injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records. I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

Name & NRIC No. _____ Date _____ Signature _____

(Company's Stamp, if applicable)