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CLAIM FORM – WORK INJURY COMPENSATION 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

Please answer ALL the questions. If the questions are not applicable, please fill in N.A.

EMPLOYER'S PARTICULARS

Insured : _____
Business : _____
UEN No. : _____
Address : _____
Policy Number : _____
_____
Singapore _____
Contact Number : _____
Email : _____
Date of Accident : _____

INJURED PERSON'S PARTICULARS

Name : _____
NRIC/ Passport No. : _____
Gender : _____
Nationality : _____
Address : _____
Date of Birth : _____
_____
Contact Number : _____

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1.	State occupation in which the Injured Person is employed. Please describe his/her duties.	
2.	Was the Injured Person engaged in this occupation when the accident occurred? If not, in what capacity was the Injured Person engaged in?	
3.	Is the Injured Person in your direct employment? (a) If "No", please give name of the employer (b) Address of the employer (c) Name of employer's insurer	☐ Yes ☐ No
4.	When did the Injured Person enter your service?	
5.	(a) Name of hospital / clinic that Injured Person was taken to (b) Medical treatment received (i.e. In-patient / Out-patient or others) (c) Is the Injured Person still warded or discharged? If discharged, please provide discharge date & a copy of Hospital Discharge Summary	
6.	State whether the Insured Person returned to work, and if so, date returned to work.	
7.	Are you satisfied the Injured Person has met with a bona-fide accident of employment?	
8.	Is the Injured Person able to do partial work?	
9.	What is the probable period of disablement (approximate)?	

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10.	(a) Has the accident been reported to the Ministry of Manpower (MOM)? (b) If yes, please provide date reported & a copy of the iReport (c) Has the accident been reported to the police (if applicable) (d) If yes, please provide date reported & a copy of the Police report	☐ Yes ☐ No ☐ Yes ☐ No
11.	Date and Time of Accident	
12.	Place of Accident	
13.	(a) Was there any project involved? (b) Title/Particulars of project (if applicable)	
14.	Is your company involved in the above project as sub-contractor?	☐ Yes ☐ No
15.	Did the accident occur on board a vessel?	☐ Yes ☐ No
16.	(a) When did you receive notice of accident and from whom? (b) If in writing, please attach to this form.	
17.	On what date did the Injured Person actually cease work?	
18.	Briefly describe what was the cause of the accident and how it happened	

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Claim Form – Work Injury Compensation Insurance

19.	If from machinery or gearing: (a) Was it fenced or guarded (b) Was it being cleaned whilst in motion?	
20.	Briefly describe the nature of injury sustained. Kindly state the regions injured.	
21.	What was the general nature of the contract or work going on?	
22.	Was the Injured Person under the influence of drink or drugs at the time of accident?	
23.	Was the injured person guilty of any misconduct or disobedience to orders or rules? If so, please give full particulars	
24.	State the names of any person(s) who witnessed the accident.	

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Claim Form – Work Injury Compensation Insurance

Gross Monthly Earnings Preceding Date of Accident (Twelve months immediately prior to the date of this Accident, or during such shorter period as he/she may have been in the Employer's service).

Note: Earnings of employee excludes travelling allowance, contribution paid by employer towards Central Provident Fund (CPF) and money paid to employee to cover any special expense incurred by him by reason of his employment.

MONTH	GROSS MONTHLY EARNINGS (EXCLUDE BONUS)	ANNUAL WAGES SUPPLEMENT/ BONUS PAID DURING LAST 12 MONTHS
TOTAL		
AVERAGE	(1)	(2)

Total Average (1) + (2) = _____

Working days per week (please tick ✓)

☐ 5 days ☐ 6 days

☐ 5 ½ days ☐ Others _____ (please specify)

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 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.

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Company Stamp and signature Date

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Claim Form – Work Injury Compensation Insurance

DOCUMENTS REQUIRED (COPIES UNLESS ORIGINAL STATED)

Please note that this list is not exhaustive and additional information and/or documents may be required in certain circumstances.

Please tick against the documents that you have submitted
☐ Original Medical Certificates
☐ Original Medical Bills
☐ Medical Reports / A&E or Inpatient Discharge Summary – if any
☐ NRIC for Singaporeans
☐ Work Permit and Passport for foreign workers
☐ MOM iReport
☐ Payslips / Wage payment vouchers – 12 months before month of accident
☐ Duty roster for period of Medical Leave – if any (for shift employees)
☐ Internal Incident report – if any
☐ Contract Agreements for accidents involving projects
☐ Police Report/Accident Report – if applicable, for example: traffic accident claim
☐ Death Certificate – for death claim
☐ Others, please specify: _____