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INSUREHEALTH - 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 ('UOI', herein called the Company). 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.

PART I (To be completed by Insured or Claimant if Insured is a minor)

Name of Insured	NRIC/ Passport No.		Type of Policy and Policy No.
Address	Age	Gender	Tel No.(Mobile/ Home/ Office)
1 Present occupation (if more than one, state all)			
2 Name, address of business or employer			
3 (a) Date, time and place of accident / injury *OR* (b) Inception date of sickness / illness	Accident – *OR* Sickness –		
4 (a) If accident / injury, please state full description on how it happened. *OR* (b) If sickness / illness, please state full description of sickness / illness from which you are now having.			
5 If you had a history of similar accident / illness and/or sickness / injury 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.			
6 Name and address of doctor(s) who treated you and consultation date(s).			
7 Details of hospitalisation: (Please attach hospital bill) (a) Name of hospital; and (b) period of hospitalisation			
8 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?			
9 Name and address of any witness of the accident/ injury.			
10 Name and address of your usual Attending Doctor/ Clinic/ Hospital.			

11 Are you making any other insurance or compensation claim as a result of this injury or sickness? If yes, state:

Name of Insurance Company	Policy No.	Amount of Benefits	Date of Insurance Effected

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 hereby authorize any hospital doctor or other people who has attended to me to furnish UOI 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/ Passport No. _____ Date_____ Signature_____

MEMBER OF THE UOB GROUP

PART II Attending Physician's Statement (To be completed by the doctor at Insured's expense)

Name of patient : NRIC/ Passport No.:	Date Admitted : Date Discharged :
1 Is condition due to sickness or injury? Please state details of the condition.	(a) ☐ Sickness (b) ☐ Injury
2 Was the patient referred to you by a general practitioner? If so, please indicate his/her name and address.	
3 (a) Of what symptoms did the patient complain? (b) When did patient first consult you for this condition?	(a) (b)
4 (a) According to the patient, how long had he/she been experiencing these symptoms? (b) How long do you feel the symptoms had lasted?	(a) (b)
5 Had the patient previously seen any other doctor on account of these symptoms? If so, please give details on the date consulted and name of doctor.	
6 (a) What was your diagnosis? (b) Did you inform the patient of your diagnosis and has any treatment been recommended? If so, when did you do so?	(a) (b)
7 Date and Type of surgery/ operation performed.	
8 What other illnesses (if any) have contributed to the patient's condition.	
9 What other pre-existing medical condition (if any) have contributed to the patient's current condition and/ or hospitalization.	
10 Is patient aware of himself/herself having this condition prior to seeing you? If so, when?	
11 Bearing in mind the patient's occupation, do you feel that the sickness or injury would have prevented him/ her from working?	
12 (a) How long was or will patient be continuously totally disabled (unable to work)? (b) How long was, or will, patient be partially disabled?	(a) Totally From _____to _____ (b) Partially From _____ to _____

13 Whether injuries sustained will result in any permanent disablement/incapacity. If so, please advise percentage of disablement/ incapacity.	
14 Was the condition of the patient due to or related to :	
(a) pre-existing medical condition	(a) ☐ No ☐ Yes _____
(b) physical or mental defect or infirmity	(b) ☐ No ☐ Yes _____
(c) pregnancy, miscarriage, abortion or childbirth	(c) ☐ No ☐ Yes _____
(d) self-destruction or intentional self-inflicted injury	(d) ☐ No ☐ Yes _____
(e) mental or nervous disorders	(e) ☐ No ☐ Yes _____
(f) Aids-related or any sexually transmitted diseases	(f) ☐ No ☐ Yes _____
(g) intoxication or under influence of alcohol	(g) ☐ No ☐ Yes _____
(h) congenital anomaly	(h) ☐ No ☐ Yes _____
(i) cosmetic reasons or dental treatment or any elective surgery	(i) ☐ No ☐ Yes _____

I hereby certify that I have personally examined and treated the patient for the above and that the facts as given above present my opinion of his/her condition.

Name of Physician: _____Stamp and Signature: _____

Name and Address of Clinic : _____ Date: _____