United Overseas Insurance Limited
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Co. Reg. No. 197100152R

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INSURECARE - 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.

Type of Claim (Please tick accordingly)
Please refer to the eligible benefits cover under the Policy

☐ Death	☐ Total / Partial Permanent Disablement
☐ Bereavement Allowance	☐ Medical/ Surgical Expenses
☐ Mobility Aids / Home Modification	☐ Fracture/ Dislocation
☐ Child Education Fund	☐ Income Aid
☐ Living Support Allowance	☐ Maid Recruitment Fee
☐ Home Nursing Care	

Policyholder Information

Policy Number	Name of Insured	NRIC / Passport Number
Address	Email	Tel No.(Mobile/ Home/ Office)
Gender ☐Male ☐ Female	Occupation	

Claimant Information (If different from Policyholder)

Name of Claimant	NRIC/ Passport Number	Relationship between Claimant and Policyholder
Address	Email	Tel No.(Mobile/ Home/ Office)
Gender ☐Male ☐ Female	Occupation	

Injury / Infectious Disease / Accident Information

1. Date & Time of Injury / Infectious Disease / Accident: (DD) (MM) (YY) (Hours) (Mins) ☐AM ☐PM
2. Where and how did the Injury / Infectious Disease / Accident occur? In the case of Infectious Disease, when did the symptom(s) appear and what were the symptom(s)?
3. Nature and extent of the injury & part of the body affected:
4. If you had a history of Injury / Infectious Disease / Accident before, please give details of insurer, date of diagnosis and type of treatment received. Please specify recovery date (if any).

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5. Is this a work-related Injury/ Infectious Disease/ Accident? Yes / No

If yes, please state the name of the insurance company for Work Injury Insurance and the policy no.

6. Name and address of any witness of the accident

7. Are you making any other insurance or compensation claim as a result of this Injury/ Infectious Disease/ Accident? If yes, please state the details. Should there be any claim(s) settlement from another insurer, please provide their settlement of claim(s) letter and detailed breakdown of the claim(s) settled.

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

Medical Information

Name of Clinic / Hospital	Contact No

Address

Admission Date (DD) (MM) (YY)	Discharged Date: (DD) (MM) (YY)

Diagnosis and Type of Treatment Received

No. of Medical Leave Days

Claim Payment: Please tick one (1) option.

☐ **Direct Credit**	Name of Bank	Account Holder Name	Bank Account Number

☐ **Cheque** (Payee Name as per Name of Insured)

Declaration

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 representative 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_____

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Documents Required
(Please mail to 146 Robinson Road #02-01 UOI Building, Singapore 068909 or email to contactus@uoi.com.sg)

- Duly completed and signed Claim Form

Medical & Surgical Expenses Claim

- Inpatient Discharge Summary report, if hospitalized and/or other medical investigation reports stating the accidental injury or diagnosis
- Doctor's memorandum/certification letter stating the nature of accidental injury or diagnosis
- Police Report, if the Injured / Insured person was involved in a motor vehicle accident or any accident that required such report to be lodged
- Injured's/ Insured Person's Driving License if he/ she was driving at the time of accident
- All related final hospital bill, detailed bill, medical tax invoice and/or official receipt
- All related medical certificates issued by the same treating hospital stating the confinement period
- Detailed bill / invoice stating the diagnosis, treatment and medication prescribed for an accidental injury treatment sought at a registered Traditional Chinese Medicine/ Chiropractic clinic

Accidental Death Claim, Bereavement Claim, Child Education Fund Claim

- Police Report, if the Injured/ Insured person was involved in a motor vehicle accident or any accident that required such report to be lodged
- Deceased's Driving License, if driving at the time of accident
- Death Certificate (Certified True Copy)
- Coroner's Report, if any
- Autopsy Report/ Post Mortem Report/ Toxicology Report, where applicable
- Grant of Probate or Letters of Administration
- NRIC/ Identity Card/ Work Permit Card (Front and Back)
- Marriage Certificate (for a Spouse claim)
- Birth Certificate

Total/ Partial Permanent Disablement Claim, Income Aid Claim, Mobility Aids & Home Modification Claim, Fracture & Dislocation Claim, Maid Recruitment Claim, Living Support Claim, Home Nursing Care Claim

- Medical report, X-ray and/or other medical investigation reports stating extent of the Injured's/ Insured Person's accidental injury
- Doctor's memorandum/certification letter stating the Injured's/ Insured Person's nature of injury, i.e., total or partial disablement and an update of the latest medical condition
- Police Report, if the Injured/ Insured person was involved in a motor vehicle accident or any accident that required such report to be lodged
- Injured's / Insured Person's Driving License, if he/she was driving at the time of accident
- Attending physician's certification letter/ memorandum/ referral letter for mobility aids or home modification to cope with the permanent disablement of 50% or more
- All related detailed bill, tax invoice and/or official receipt on the expenses/ fees and/or charges incurred
- NRIC/ Identity Card/ Work Permit Card (Front and Back)
- Marriage Certificate (for a Spouse claim)
- Birth Certificate

Note:

- Please refer to the eligible benefits cover under your policy.
- Should there be any claim(s) settlement from another insurer, please provide their settlement of claim(s) letter and detailed breakdown of the claim(s) settled.
- The list of documents requested for our claim assessment is not exhaustive and we may need your co-operation to provide the additional information and/or documents if necessary.
- Any documents or reports required to process this claim shall be furnished at the expense of the Policyholder / Claimant.