Member of the UOB Group

United Overseas Insurance Limited

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Co. Reg. No. 197100152R

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.

To be completed by Insured or Claimant if Insured is a minor

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

Claim Related Information	
1 Present occupation (if more than one, state all)	
2 (a) Date, time and place of accident / injury *OR* (b) Inception date of sickness / illness	Accident: *OR* Sickness:
3 (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.	
4 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.	

5 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

Claim Payment: Please tick		
☐ Payee's Bank Account Number	Name of Bank	Account Holder Name
☐ Cheque payment in favour of		

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 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_____

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Documents Required	
• Copy of Hospital Inpatient Discharge Summary/ Clinical Discharge Summary • Copy of Hospital Bill/ Tax Invoice	• Receipt for Ambulance Service • Any other relevant documents to support the claim