

OMAN UNITED INSURANCE CO. S.A.O.G.



الشركة العامة للتأمين والتأمينات عمان ج.م.ع

SECURITY SERVICES

CLAIM FORM – DISABILITY

1. Name of the Member (Mr./ Ms.):
2. Occupation :
3. Policy / Endorsement No. :
4. Date of Birth (Proof to be enclosed) :
5. Salary and benefit as at date of disablement (RO) :
6. Date of Joining :
7. Date last at work :
8. Original Sum Insured (RO) :
9. Sum Insured as on the Date of Disability (RO):
10. Cause of Disability :
11. Date of Disability:
12. Percentage of Disability :

We hereby declare and certify that the above details given are true and complete , that the above member was eligible , was included in the declaration of members declared to the Insurer and was our employee as at the date of the Disability. Further, we undertake to provide additional information, if any, required by the Insurer.

Dated on this Day of 200..... At

Claimant's Name & Signature:

Address with Seal

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Witness :

Name :

Signature :

Address :

Note That Following Documents to be enclosed:

- Disability Certificate (original) from Compensation Board Ministry of Health.
- Age proof (ID card copy/Residence Card copy/Passport copy).
- Medical Certificate and accompanying Medical Reports indicating the cause of disability obtained from a board authorized by MOH.
- Hospitalization Report/Discharge summary.
- Police Report in case of unnatural events.
- Accident report in case of disability due to accident.
- Proof of salary payment for 3 month prior to incidence.
- Employment Agreement copy.
- Resident Card Copy.
- Others (if any) as required by insurer

Disability and Birth Certificates must be attached **in original** and they will be returned after due verification.