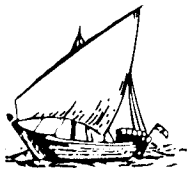

Oman Insurance Company (P.S.C.)

P.O. BOX 5209, DUBAI - U.A.E.

CLAIMANT'S STATEMENT

This form is given on receipt of notice of an accident/illness, and its issue is in no way an admission of a claim.

Name in full : ..... Policy No. : ..... Age : .....

Profession, Business or Occupation : .....

(if more than one, state all)

If an Employee, give name, address and business of Employer : .....

.....

---

1. Is claim for Accident? .....Illness? .....
2. Date of accident or date you first became ill : .....
3. Place and time of accident : .....

   Did accident or illness occur at work? Yes ..... No .....
4. If accident, describe how it happened : .....

   .....
5. If accident, what injuries have you sustained : .....

   .....

   (If to an eye, hand or arm, foot or leg, please state whether it is the Right or Left)
6. Name and address of witnesses of the accident :

   a : .....

   b : .....
7. Name and address of the Police Station where the accident was reported : .....

   (Please submit a copy of the Police report)
8. Date you first saw doctor for this condition : .....
9. Name and address of Attending Physician : .....
10. Dates of Doctor's treatment

    At Home : .....

    At Doctor's Clinic : .....

    Confined in Hospital : From : ..... To : .....
11. Were you disabled? Yes : ..... No: .....

    If yes, show first date you were unable to work due to this condition : .....
12. Date you were physically able to start work

    Completely : ..... Partially : .....
13. If now disabled when will you be able to return to work ? .....
14. Were you confined to the house : Yes : ..... No : .....

    If yes, show dates continuously confined to the home : From : ..... To : .....

AUTHORIZATION : I authorize any physician, hospital, insurer or other organisation or person having any records, data or information concerning this accident/illness, to furnish such records, data or information as may be requested by Oman Insurance Co. PSC. or their duly authorized representative. I understand that in executing this authorization, I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original.

Dated at ..... this ..... day of ..... 20.....

Signature of Claimant

Oman Insurance Company (P.S.C.)

P.O. BOX 5209, DUBAI - U.A.E.

DOCTOR'S CLAIM REPORT

It is very essential that full particulars be given so that the Medical Officer of Oman Insurance Co. may understand the exact nature and extend of the illness/ injuries.

Patient's Name : ..... Age : .....

Policy No. : .....

---

1. Diagnosis (Please describe complications, if any) : .....
   Is this condition primary ? Yes : ..... No : .....
   If no, what is it secondary to ? .....
2. Is this Illness ? ..... Accident ? ..... Pregnancy ? .....
   Date first consulted for this condition : .....
   Cause of this accident/illness : .....
3. If accident, date : .....
   THE INJURIES SUSTAINED (IF TO AN EYE, HAND OR AN ARM, FOOT OR LEG) STATE WHETHER IT IS THE RIGHT OR LEFT

Regions Injured	Nature and Extend of Injuries
.....	.....
.....	.....
.....	.....

4. If pregnancy, what was expected date of full term delivery ? .....
5. Any previous medical attention for this condition ? Yes : ..... No : .....
   If yes, date : ..... Doctor's Name & Address : .....
6. If Illness, date symptoms first noticed : .....
   By whom : .....
7. For what have you previously treated patient ? .....
8. Are you aware of anything in the previous medical history of the Claimant which might have contributed, directly or indirectly, to the occurance of the accident or which may be likely in any way to retard his recovery from it ?
   .....
9. If patient has any chronic or constitutional disease, physical defect or deformity, please give diagnosis : .....
   ..... Date first noted : .....
10. What operation was performed for present condition ? .....
11. Dates you treated patient for present condition
    At Clinic : .....
    At Home : .....
    At Hospital : .....
12. Date disabled from permorming usual duties :
    Totally from : ..... to .....
    Partially from : ..... to.....
13. Was patient confined to the home ? If yes, give dates : From : ..... to : .....
14. Was patient confined to the hospital ? If yes, Name : .....
    Confined from : ..... to : .....
15. If still disabled when will he probably be able to resume duties ? .....

Degree : ..... Signature of Attending Physician : .....

Seal of Attending Physician : .....

Date : ..... Address : .....

Oman Insurance Company (P.S.C.)

P.O. BOX 5209, DUBAI - UNITED ARAB EMIRATES

PROOF OF DEATH - PHYSICIAN'S STATEMENT

Policy No. ----------

1. Name of deceased in full ----------

2. Residence at time of death ---------- (Street) (City) (State)

3. Age last birthday ---------- 4. Date of death ---------- Day ---------- Month ---------- Years ----------

4. Was death due to: ☐ natural causes ☐ accident ☐ suicide ☐ homicide
If from accident, suicide or homicide, please give details:

5. Immediate cause of death ---------- Duration: ---------- Year ---------- Months

Contributory cause of death ---------- Duration: ---------- Year ---------- Months

6. Was there an autopsy? ☐ yes ☐ no If yes, by whom and with what result?

7. From known history of the case when did first symptoms become apparent?

----- Day ---------- Month ---------- Years 7a. Date of first visit in last illness: ----------

Source of history obtained: ----------

8. Give dates of treatment for last illness:

At hospital: from ---------- 20 ---------- to ---------- 20 ----------

At home from ---------- 20 ---------- to ---------- 20 ----------

At office or clinic from ---------- 20 ---------- to ---------- 20 ----------

Name of hospital ----------

Address: ----------

9. What chronic condition or deformity did deceased have, if any?

10. Was deceased ever admitted to any institution, sanitarium, hospital, etc. ☐ yes ☐ no

If so for what condition?

Dates of confinement: from ---------- 20 ---------- to ---------- 20 -----

Where confined : ----------

Address: ----------

11. For what other illnesses had you treated deceased during past five years? Dates of attendance?

12. Give names and addresses of any other physicians or practitioners who attended or advised deceased during past 7 years:

Doctor's Name and Address Diagnosis Date Treated

---

13. Remarks and supplementary data, if any:

Date ---------- 20 ---------- Signed ----------

Oman Insurance Company (P.S.C.)

P.O. BOX 5209, DUBAI - U.A.E.

BENEFICIARY'S CLAIM FORM

TO GET FAST SERVICE, PLEASE DO THIS

1. List all policy numbers
2. Answer all questions
3. Sign authorization below
4. Attach all policies
5. Attach certified copy of death certificate
6. Return everything to the above address

LIST ALL OIC POLICY NUMBERS .....

FULL NAME OF THE DECEASED ..... Sex .....

If married Female, give Maiden Name .....

ADDRESS OF DECEASED ..... (Street) ..... (City) ..... (State)

DATE OF DEATH Month ..... Day ..... Year ..... DATE OF BIRTH Month ..... Day ..... Year .....

FROM WHERE DID YOU GET THIS DATE OF BIRTH (PASSPORT birth certificate, etc.) ? .....

1. Give the following information about each beneficiary of this policy :

Name	Date of Birth	Address	Relationship

2. Show date deceased first saw a doctor for condition that caused death : .....

   Was death due to : Illness? ☐ Accident? ☐ At work? Yes ☐ No ☐

   If accident, give full details below and attach newspaper clippings : .....

3. Name and address of Family Doctor : .....

4. Names and addresses of all doctors who attended or treated deceased in past 5 years :

5. Names and addresses of all hospitals, the deceased was ever treated at or admitted to : (show dates)

6. In what other companies did deceased have Life and Hospital or Medical Insurance ?

   Give Names, amounts, and policy numbers:

Be sure to sign below

AUTHORIZATION : Policy Number ..... Deceased .....

I authorize any physician, hospital, insurer, Medical Information Bureau or other organization or person having any records, data or information concerning health history of the deceased to furnish such records, data or information as may be requested OMAN INSURANCE COMPANY or their duly authorized representative. I understand that executing this authorization, I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original.

Date ..... Signed .....

Address .....