Disability Claim Procedure
Group Life Insurance

Claim Intimation
To register the claim, claimant needs to intimate us within 30 calendar days from the date of the event. To send an intimation, please send an email to life.claims@tameen.ae with the below details. Claim reference number will be sent within 3 working days of receiving the intimation email.

1. Group life policy number
2. Employee Name
3. Employee Number
4. Date of Joining
5. Date of Birth
6. Date of Accident/Sickness
7. Pace of Accident/Sickness
8. Details of Accident/Sickness
9. Basic Monthly Salary at the time of event

Claim Processing
For processing the claim, please send the claim form with the below documents to life.claims@tameen.ae within 30 days of receiving the claim reference number from us. In case we need any additional documents or require you to submit the originals, we will get in touch with you. For any queries or follow up on your settlement, please write to us at life.claims@tameen.ae.

1. **General Documents**
   - Duly filled Disability claim form
   - Claim reference number
   - Medical report from treating doctor detailing the diagnosis and treatment provided
   - Doctor's prescription for medicines purchased
   - X-ray and Laboratory reports for the lab bills submitted
   - 3 month salary slip prior to date of event. This should include breakup of basic salary and fixed allowances.
   - Passport and visa page

2. **Additional Documents**
   - **Permanent Total and Partial Disability:** Disability certificate provided by the Government Medical Board in UAE.
   - **Temporary Total Disability:** Original sick leave certificate for the period of absence from work. **Accidental Medical Expenses:** Original medical expenses invoices

Original documents will need to be sent to Oman Insurance Company, Life claim Department, Al Rigga Business Centre, 3rd Floor, Al Rigga Street, P.O Box 5209, Dubai, United Arab Emirates. Oman Insurance Company reserves its right to ask for additional documents as may be required and relevant for claim assessment.

Claim Settlement
If the claim is approved, discharge receipt will be sent to the client for confirmation of the claim amount payable within 7 working days of submitting the claim forms and the documents.

The client needs to sign and stamp the discharge receipt. Once this is received, the amount will be transferred to the bank account within 14 working days.

Forward together

شركة عمان للتأمين
Oman Insurance Company

Disability Claim Form
Group Life Insurance

All fields are mandatory. Please complete this form using black or blue ink. Write in BLOCK LETTERS and tick the relevant items. If the form is incomplete it might cause a delay. Kindly ensure that you submit a fully filled form together with the signed annexes, if applicable. Please retain a copy of this claim form and other correspondences with us for your future reference.

1.	Policy and Employee Details			
A.	Policy Number	O I G		
B.	Company Name			
C.	Sub-company Name (if applicable)			
D.	Sum Insured		Currency	
	Employee Details			
E.	Employee Name			
F.	Date of Birth		Gender	☐ Male ☐ Female
G.	Employment Status	☐ Temporary ☐ Permanent	Employee Number	
H.	Work Location		Date of Joining	
I.	Designation			
J.	Salary with breakup (as per currency stated in the policy)			
K.	Date of Event		Place of Event	
L.	Cause of Disability	☐ Accident ☐ Sickness		
M.	Diagnosis			
N.	Treatment Details			
O.	For Disability due to sickness, please specify when was the condition first diagnosed			
	Benefits Claimed (please tick whatever applies as per your policy)			
P.	☐ Permanent Total Disability/Permanent Partial Disability		Disability Percentage	
Q.	☐ Temporary Total Disability			
R.	☐ Accidental Medical Expenses			

2.	Policyholder Bank Details			
A.	Account Name		Account Number	
B.	Bank Name			
C.	IBAN (23 digits)			

3. Temporary Total Disability – Sick Leave Details (if applicable)

A. Leave Start Date | End Date

B. Please provide details of any intermittent sick leaves taken.

From	To	Reason

4. Accidental Medical Expenses (if applicable)

Please provide details of all the medical expenses. Use additional sheet if required.

Service Description	Provider Name	Currency	Claimed Amount

5. Claimant Declaration

I hereby declare that the particulars mentioned above are true and correct to the best of my knowledge.

Name				Designation	
Signature		Date		Stamp	

6. Beneficiary or Legal Representative Declaration

I hereby authorize Oman Insurance Company to wire transfer claim payouts (if any) related to this claim form to the above bank details as filled in by me. I understand that Oman Insurance Company reserves its right to use any alternate payout option if required. If ever Oman Insurance Company credits more amount than the correct benefit amount due to duplicate or erroneous funds transfer, I authorize Oman Insurance Company to revise the transaction and withdraw the overpayment. I will not hold Oman Insurance Company responsible in any case of non-credit to the above bank account or if the transaction is delayed or not effected at all for reasons of incomplete/incorrect details filed in by me.

I by signing this form hereby confirm that I am duly legally authorized to fill and claim the policy benefit under the above mentioned policy. I hereby declare that above statements are true in each and every respect. I hereby authorize and provide my unconditional consent to any physician, hospital, insurer, medical information bureau or other organization or person having any records, data or information concerning health history of the deceased life insured to furnish such records, data or information as may be requested by Oman Insurance Company or their duly authorized representative to be provided to Oman Insurance Company and for Oman Insurance Company to further release such received and/or policy and claim related information to any other entity as may be required or requested. I understand that in executing this authorization, I waive the right for such information to be privileged or confidential. I hereby also agree to indemnify and hold harmless Oman Insurance Company against all costs, expenses and liabilities which may arise as a result of this claim/claim form including any of the details filled in by me in this claim form. A photocopy of this authorization shall be considered as effective and valid as the original.

Name		Date	
Signature		Relation with Insured	