ATTACHMENT B5

Date :

UNI CITY NETWORK ENTERPRISE (001405564-M)
No 1213, Block A4, 12th Floor,
Leisure Commerce Square, 46150 Petaling Jaya, Selangor
Tel: 03-78742660 Fax: 03-78741768
Email: unicitykl@gmail.com Website: www.ucn.my
Claim Care Line: 012-5382660 Email: ucnclaim@gmail.com

Dear Sir / Mdm,

RE : FOREIGN WORKER COMPENSATION SCHEME (FWCS)
NOTIFICATION OF CLAIM UNDER
MEDICAL EXPENSES ( )
HOSPITALISATION & SURGICAL EXPENSES ( )
PERMANENT DISABLEMENT & TEMPORARY DISABLEMENT ( )
The Insured :
Worker's Name :
Passport Number :
Policy Number :
Date Of Accident :
Period Of Coverage :

We enclosed herewith the relevant documents for the above claim :-

1) Copy of P.P.2 Form ( )
2) Copy of Lab 90 Form ( )
3) Original Medical Receipts with Itemized Bills ( )
4) Copy Medical Certificate / Medical Leave from Doctor ( )
5) Copy Of Worker's Passport **&** Date Of Entry ( )
6) Copy of Work Permit ( )
7) Copy of P.P.5 Form / P.P. 6 Form (Labour Assessment) ( )
8) Copy Of Policy Schedule ( )
9) Copy of 6 Months Salary Slip Prior to Date of Accident ( )
10) Original/Copy of Police Report (If available/related) ( )
11) E-PAYMENT FORM ( )

Kindly acknowledge receipt for the above documents.

Thank you.

CLAIM SUBMITTED BY:	**ACKNOWLEDGED BY UCN:**
______________________	______________________
Company Chop & Signature	**Company Chop & Signature**
Name :	**Date :**

www.ucn.my