HongLeong Assurance

C013713030

Claim No. : _____ Submission Branch : _____

Agent Who Submits the Claim : _____ Date Customer Informed Agent of the Claim : _____

HOSPITALISATION BENEFIT / HOSPITAL INCOME / HOSPITAL & SURGICAL / PERSONAL ACCIDENT / DISMEMBERMENT / OUTPATIENT DENGUE/ZIKA / LOSS OF TRAVELLING DOCUMENTS BENEFIT CLAIM APPLICATION FORM

This form is to be completed by the person entitled to the policy monies.

Part I – Particulars of Policy and Life Assured (Event Person)

1. Policy No.:	2. Name :
3. I/C No.: (new) (old)	4. Contact No.:
5. Email Address:	6. Occupation:
7. Address:	

Part II – Particulars of Policies Preferred for Claim (in Descending Order of Preference) – Only applicable for Hospital and Surgical claim

If the Life Assured is covered by more than one insurance policy or rider which grants Hospital and Surgical Benefit issued by the Company, you must decide which insurance policies or riders you are making a claim under when you are making a claim; if you do not decide, the Company will in its sole discretion make a decision on your behalf. A decision once made is final and you will not be allowed to subsequently make the claim under another insurance policy or rider.

1st Preference: (Policy No. and Rider)	2nd Preference: (Policy No. and Rider)
3rd Preference: (Policy No. and Rider)	4th Preference: (Policy No. and Rider)

Part III – Particulars of Life Assured's (Event Person's) Employment Details

1. Name of Employer:	2. Nature of business:
3. Contact No.:	4. Date First Employed (dd/mm/yyyy):
5. Address of Employer:	

Part IV – Particulars of Accident

1. Date and Time (dd/mm/yyyy): am / pm	2. Place:
3. Describe fully how the accident occurred:	4. If injuries/ dismemberment were not due to accident, please provide underlying cause:
5. State as precisely the injuries you have sustained, indicating the part of the body injured and the type of injury (e.g. fracture, cut, bruise, etc.).	6. a) Date last attended work (dd/mm/yyyy): b) Date returned to work (dd/mm/yyyy):
7. Day(s) of medical leave:	

Part V – Particulars of Loss of Travelling Documents

1. Date and Time (dd/mm/yyyy): am / pm	2. Place:
3. Describe fully how the incident occurred:	

Part VI – Particulars of The Illness / Disability

1. Nature of illness / disability:	2. Date of diagnosis (dd/mm/yyyy):
3. Date symptom(s) first noted (dd/mm/yyyy):	4. Duration of symptom(s):
5. Symptom(s) of illness / disability:	6. Name of hospital admitted:
7. Date of admission (dd/mm/yyyy):	8. Date of discharge (dd/mm/yyyy):

Part VII – Particulars on Doctors Consulted

	First Treatment Date (dd/mm/yyyy)	Name and Address of Doctor(s)
1. First doctor consulted for this illness / disability.		
2. All other doctors consulted for this illness / disability.		
3. Regular doctors.		
4. All other doctors consulted in the past five (5) years.		

Part VIII – Particulars on Past Medical History

	Date of Diagnosis/ Onset (dd/mm/yyyy)	Name & Address of Doctor(s) Consulted	Dates of Consultation (dd/mm/yyyy)
1. Hypertension.			
2. Diabetes Mellitus.			
3. Cardiovascular Disease.			
4. Other Illnesses / Injuries. Please specify: a) b)	a) b)	a) b)	a) b)

Part IX – Particulars on Other Policy / Policies

Name of Insurance Company	Policy No.	Policy Effective Date (dd/mm/yyyy)	Sum Assured

Part X – Payment instruction on claim monies

1. ☐ By Direct Credit / E-payment.
2. ☐ Utilise claim monies for investment into this Unit Linked Policy. This is subject to Sales and Service Tax (SST) for corporate owned policy. Reinvested amount will follow the existing fund allocation and type. For Level Cover, the Basic Sum Assured shall not be increased by the top up amount.

By default, Hong Leong Assurance Berhad will pay claim monies via Direct Credit / E-payment.

Part XI – Payment instruction on Unutilized Hospital Room & Board

1. ☐ By Direct Credit / E-payment.
2. ☐ Utilise Unutilized Hospital Room & Board for investment into this Unit Linked Policy. This is subject to Sales and Service Tax (SST) for corporate owned policy. Reinvested amount will follow the existing fund allocation and type. For Level Cover, the Basic Sum Assured shall not be increased by the top up amount.

By default, Hong Leong Assurance Berhad will utilise Unutilized Hospital Room & Board for investment into this Unit Linked Policy.

Part XII- Details for Direct Credit / E-payment for Claim Payment

Single owned account is preferred but in the case of jointly owned account, the payee's name has to appear as the first account holder. In the event that you had provided to Claims Department on the bank details earlier but you wish to deposit the claim monies / unutilized Hospital Room & Board into another bank account, please fill up the Details for Direct Credit / E-payment under Part XII. Otherwise, payment will be made to latest bank account submitted to Claims Department.

1. Name of Payee:	2. Identity Number of Payee:
3. Name of Bank:	4. Bank Account Number:
5. Contact No. :	6. Email Address:

Part XIII- Particulars of Policy Owner/ Beneficial Owner

1. Details of Policy Owner

1. Name of Policy Owner:	2. I/C No.: (new) (old)
3. Contact No.:	4. Email Address:
5. Address:	

2. Details of Beneficial Owner (For Policy Owned By Entity)

a) Entity Name:

b) Entity Registration No.:

In the event of the space provided is insufficient, please provide the information by attaching separate declaration forms.

	Beneficial Owner 1	Beneficial Owner 2	Beneficial Owner 3
Name			
I/C No./ Passport No.			
Contact No.			
Designation			
Correspondence Address			

3. Politically Exposed Person (PEP) Declaration

Notes:

1. All names as per NRIC/Passport.
2. Politically Exposed Persons (PEP)
   a) are individuals who are or who have been entrusted with prominent public function (Head of State or Government, senior politicians, senior government, judiciary or military officials, senior executives of state owned corporations and important political party officials)
   b) persons who are or have been entrusted with a prominent functions by an international organization which refers to members of senior management. (Directors, deputy directors and members of the board or equivalent functions)
3. Family Members and Close Associates
   a) Family Members
   are individuals who are related to a PEP either directly (consanguinity) or through marriage. This includes parents* , siblings*, spouse (s), child* or spouse's parents*.(*biological and non biological relationship)
   b) Close Associates
   is any individual closely connected to a PEP, either socially or professionally and may include extended family members such as relatives (biological or non biological relationship), financially dependent individuals (persons salaried by the PEP such as drivers, bodyguard, secretaries, business partners or associate, prominent members of the same organization as the PEP, individuals working closely with the PEP ie. work colleagues , close friend)
4. Beneficial Owner
   Refers to any natural person(s) who ultimately owns or controls a customer and/or the natural person on whose behalf a transaction is being conducted. It also includes those natural persons who exercise ultimate effective control over a legal person or arrangement. Reference to "ultimately owns or control" or "ultimate effective control" refers to situations in which ownership or control is exercised through a chain of ownership or by means of control other than direct control. This also refers to any natural person(s) who ultimately owns or controls a beneficiary, where specified in this document.

Please tick (√) the appropriate box

1. Does Policy Owner or any Beneficial Owner(s) as stated in Section 1 and 2 of Part XI hold, or has previously held or is being considered for a prominent public position?

☐ Yes ☐ No

If yes, please elaborate:

Name of Policy Owner or beneficial owner(s)	Position Held	No. of Years

2. Does any of the Policy Owner or Beneficial Owner(s)'s immediate Family Members/Close Associates hold, or previously held or is being considered for prominent public position?

☐ Yes ☐ No

If yes, please elaborate:

Name of Policy Owner or Beneficial Owner(s)	Details of Immediate Family Members/Close Associates			
	Name	I/C No./ Passport No.	Position Held	Relationship to Policy Owner or Beneficial Owner(s)

Part XIV – Declaration and Authorisation

I, the Policy Owner hereby make claim on Hong Leong Assurance Berhad ("the Company") in respect of the policy monies payable on the condition / illness / disability of the Life Assured and / or the benefits due under Policy No. / Policies Nos. _____ and agree that the written statements, reports and affidavits of any doctor who was consulted by the Life Assured or who attended to the Life Assured and all other documents furnished to the Company in support of this claim shall constitute and are hereby made a part of the proof of the condition / illness / disability of Life Assured.

2. I declare that the answers and statements given in the claim form submitted herewith are true and complete to the best of my knowledge and belief and that I have not withheld any material fact in my giving of the answers and statements.

3. I acknowledge and agree that the furnishing of this form or of any other form or document to me by the Company for completion, the acceptance of this form or of any other form or document by the Company from me or from any other person, and any act, enquiry or investigation by the Company in connection with or related to the condition / illness / disability of the Life Assured shall not constitute or be considered an admission of any liability by the Company or that there was any cover / assurance in force on the condition / illness / disability of the Life Assured, or that the Company has waived any of its rights or defences.

4. I, _____ I/C No. (New) _____ (Old) _____ the **Life Assured / Parent of Life Assured if Life Assured is below age 18 hereby authorise any employers, doctors, hospitals, clinics, insurance companies, government offices or any organizations or persons who have any records, knowledge or information, whether medical or otherwise, of _____ Birth Certificate No. _____ or I/C. No. (New) _____ to disclose to the Company such records, knowledge or information for the purpose of claim considerations.

5. I hereby consent to the deduction of any amount which may be owing by me to the Company, whether under this Policy or any other policy which I may have from the Company, from the amount payable to me in respect of the claim I am now making.

6. A photocopy of this Declaration and Authorisation shall be as valid as the original.

Dated this _____ day of _____

_____
Signature of Witness

Name :

I/C No. :

Address :

_____
Signature of Parent of Life Assured if Life Assured is below age 18

Name :

I/C No. :

_____
Signature of Witness

Name :

I/C No. :

Address :

_____
Signature of Life Assured if Life Assured is above age 18 and is not the same person as the Policy Owner

Name :

I/C No. :

_____
Signature of Witness

Name :

I/C No. :

Address :

_____
**Signature of Policy Owner

Name :

I/C No. :

Relationship to the Life Assured:

** Mandatory to be completed, signed and witnessed.

Part XIV – Claim Requirements

	Requirements	Hospital & Surgical Benefit	Hospitalisation Benefit / Hospital Income Benefit	Outpatient Treatment Dengue / Zika	Personal Accident / Dismemberment Claim	Loss of Travelling Documents Benefit
1.	Hospitalisation Benefit / Hospital Income / Hospital & Surgical / Personal Accident / Dismemberment / Outpatient Dengue/Zika / Loss of Travelling Documents Application Form This form is to be completed by the person entitled to the policy monies.	✓	✓	✓	✓	✓
2.	Medical Attendant's Report on Hospitalisation Benefit / Hospital Income / Hospital & Surgical / Personal Accident / Dismemberment Claim This report must be completed by a registered medical practitioner at the Claimant's own expenses.	✓	✓		✓	
3.	Medical Attendant's Report on Outpatient Treatment for Dengue / Zika This report must be completed by a registered medical practitioner at the Claimant's own expenses.			✓		
4.	Original Itemised Hospital Bill(s) Original copies of itemised hospital bill(s) are required. If original copy is lost, a statutory declaration of lost must be declared and signed before a Commissioner for Oaths. An original sighted copy of the lost bill by issuing party needs to be submitted.	✓		✓	✓	
5.	Photocopy Itemised Hospital Bill(s) A photocopy of itemised hospital bill is required to prove the number of admission days.		✓			
6.	Official Receipt / Tax Invoice Original copies of receipt(s) and tax invoice(s) are required. If original copy is lost, a statutory declaration of lost must be declared and signed before a Commissioner for Oaths. An original sighted copy of the lost official receipt by issuing party needs to be submitted.	✓		✓	✓	
7.	Confirmation Letter On Incurred Expenses Being Reimbursed By Other Party Applicable if part of the medical expenses has been reimbursed / paid by other party such as Others Insurer / Employer / Socso etc. It is applicable for medical expenses reimbursement under Personal Accident claim.	✓		✓	✓	
8.	Birth Certificate / Identity Card (for non-foreigner) / Passport (for foreigner) A photocopy of event person's birth certificate, identity card (for non-foreigner) / passport (for foreigner) is required to prove event person's age if the age has not been admitted at time of insurance application.	✓	✓	✓	✓	✓
9.	Patient Card A photocopy of event person's patient card is required to facilitate extraction of medical reports by hospitals / clinics.	✓	✓	✓	✓	
10.	Payee's identity card (for non-foreigner) / passport (for foreigner) A photocopy of payee's identity card (for non-foreigner) / passport (for foreigner) for claim payment via Direct Credit / E-payment is required.	✓	✓	✓	✓	✓
11.	X-Ray Report A photocopy of the x-ray report for fracture injury, dislocation of bone and amputation injury.	✓			✓	

	Requirements	Hospital & Surgical Benefit	Hospitalisation Benefit / Hospital Income Benefit	Outpatient Treatment Dengue / Zika	Personal Accident / Dismemberment Claim	Loss of Travelling Documents Benefit
12.	Serologic testing (RT-PCR) / Positive isolation of relevant virus / laboratory / relevant hospital report(s) A photocopy of laboratory / relevant hospital report(s) is / are required for Outpatient Treatment Dengue/Zika claim.			✓		
13.	Medical Leaves / Light Duty Certificate(s) A photocopy of medical leave / light duty certificate(s) is / are required for claim on temporary disablement indemnity benefit. This serves only as a guide for company on assessing the claim.				✓	
14.	Newspaper Cuttings This is required if the incident is reported in the newspaper.	✓	✓		✓	✓
15.	Police Report Original sighted copy of police report is required if event is related to accident or loss of travelling documents.	✓	✓		✓	✓
16.	Certification / Letter from Life Assured's Home Embassy located overseas on the loss of Passport (Inclusive of Visa, if any) To prove the loss and replacement of Passport / Visa.					✓
	Note: 1. Certification of documents as "Original Sighted" should only be done by either Solicitor, HLA Head Office and Branch Executive / Manager, Agency Manager or Unit Manager. Our company reserves the right to call for the original documents if the case warrants the sighting of the original documents during the course of the claim processing.					