HongLeong Assurance

C013713030

Claim No. : _____

Agent Who Submits the Claim : _____

Submission Branch : _____

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.: Fax 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.: Fax 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

1. Hong Leong Assurance Berhad will pay claim monies via Direct Credit / E-payment. Please fill up the Direct Credit / E-payment Form under Part XV if it had not been submitted to Claims Department earlier.
2. In the event that you had submitted the Direct Credit / E-payment Form to Claims Department earlier but you wish to deposit the claim monies into another bank account, please fill up the Direct Credit / E-payment Form under Part XV.
3. In the event that the claim monies cannot be credited into the bank account, please tick your preference on how the cheque should be channelled to you.
   - ☐ To be collected at our HLA branch. : _____ (location of branch)
   - ☐ To be delivered by your Agent.
   - ☐ To be sent to the address of Payee.

Part XI- 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.: Fax 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 XII – 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. 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 XIII – 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 if the identity card number is not stated in the bank documents or illegible.	✓	✓	✓	✓	✓
11.	Bank Passbook / Bank Statement For claim payment via Direct Credit / E-payment.	✓	✓	✓	✓	✓

	Requirements	Hospital & Surgical Benefit	Hospitalisation Benefit / Hospital Income Benefit	Outpatient Treatment Dengue / Zika	Personal Accident / Dismemberment Claim	Loss of Travelling Documents Benefit
12.	Direct Credit / E-payment Form For claim payment via Direct Credit / E-payment. This form is to be completed by the person entitled to the policy monies.	✓	✓	✓	✓	✓
13.	X-Ray Report A photocopy of the x-ray report for fracture injury, dislocation of bone and amputation injury.	✓			✓	
14.	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.			✓		
15.	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.				✓	
16.	Newspaper Cuttings This is required if the incident is reported in the newspaper.	✓	✓		✓	✓
17.	Police Report Original sighted copy of police report is required if event is related to accident or loss of travelling documents.	✓	✓		✓	✓
18.	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.					

Part XIV – Direct Credit / E-payment Form for Claim Payment

C012312100

Terms and Conditions

1. A photocopy of the bank passbook / bank statement with account details or Employer's confirmation letter on its Bank and a photocopy of the identity card (for non-foreigner) or passport (for foreigner) if the identity card number is not stated in the bank document or illegible are to be attached together with this Direct Credit / E-payment Form.
2. 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.
3. Hong Leong Assurance Berhad reserves the right to request for further and other documents to support this Direct Credit / E-payment.
4. Payment under this Direct Credit / E-payment shall be credited to the bank account of the Payee of the Policy, as stated herein.
5. Direct Credit / E-payment is only available for direct credit to banks participating in the Interbank GIRO payment system (IBG) which are subject to changes.
6. Any use of correction fluid on document(s) required for the purposes of this request for Direct Credit / E-payment will not be accepted.
7. Hong Leong Assurance Berhad reserves the right to make payment by other payment instrument if Hong Leong Assurance Berhad finds that any information and/or document(s) provided in or submitted with this Direct Credit / E-payment is incomplete, invalid, inconsistent and/or unacceptable to Hong Leong Assurance Berhad for any reason whatsoever in which case Hong Leong Assurance Berhad is not obliged to disclose.

Particulars of Policy and Payee

Policy Number : _____

Assured Member / Life Assured's Name : _____

Name of Payee : _____

Identity Number of Payee : (New) _____ (Old)_____

Name of Bank : _____

Bank Account Number : _____

Identity Number of Payee in the above Bank Account : _____

E-mail Address of Payee : _____

Hand Phone No. of Payee : _____

Declaration of Payee

1. I consent to Hong Leong Assurance Berhad using, processing and releasing the above data to its banker(s) in order to facilitate payment(s) to me by the way of Direct Credit / E-payment.
2. I confirm that I am the holder of the bank account specified above ("Account") and that the details mentioned above are correct, true and complete.
3. I authorise Hong Leong Assurance Berhad to deposit claim payment which is payable to me into the Account.
4. I agree that all future claim payments which are payable to me shall be paid into the above Account, unless I notify the Company otherwise.
5. I agree to immediately refund to Hong Leong Assurance Berhad in full any monies paid into the Account which I am not entitled to receive.
6. I acknowledge and agree that the claim payment into the Account shall be a valid discharge of Hong Leong Assurance Berhad's liability under the policy.
7. I undertake to hold harmless and keep Hong Leong Assurance Berhad indemnified for any damages, losses, claims, costs and/or expenses incurred by Hong Leong Assurance Berhad due to any action taken against Hong Leong Assurance Berhad as a result of the payment mentioned above.

_____
Signature of Witness

Name :

I/C No. :
Address :

_____
Signature of Payee

Date (dd/mm/yyyy) :