豐隆保險(亞洲)有限公司
HongLeong Insurance (Asia) Ltd.

eClaim
Scan the QR code to submit claim online

ACCIDENT INSURANCE CLAIM FORM

Note: All claims must be submitted to us in writing within 14 days after the accident and a completed Claim Form must be forwarded to us together with relevant supporting documents, e.g. medical or diagnostic report, original medical bills and Childbirth Certificate &/or Certificate of Marriage verifying relationship to the Policy Holder, etc.

Name of Policyholder: _____ Policy No.: _____

Name of Claimant: _____ Relation to the Policyholder: _____

HKID Card No.: _____ Sex: _____ Date of Birth: _____ Occupation: _____

Contact Telephone No.: _____ Email Address: _____

Address: _____

Part 1-To be completed by the Policyholder

(a) Date, time and place of accident: _____

(b) Did the accident arise out of and in the course of employment? □ Yes / □ No

(c) Full description of the accident: _____

_____

_____

_____

(d) Nature of injury: _____

(e) Name, telephone no. and address of independent witness of the accident: _____

_____

(f) Name and address of the police station concerned and case number: _____

(g)

Name and address of attending doctor / hospital	Date of visit / Hospitalization period	Amount incurred
_____	_____	_____
_____	_____	_____
_____	_____	_____

(h) Will there be any further medical consultation/treatment required? □ Yes / □ No

(i) Nature and extent of permanent disability: _____

(j) Amount of claim: Medical expenses _____ Daily cash benefit _____

Permanent disability _____(Please provide separate medical report for substantiation)

(k) Do you have any other insurance policies covering the accident? □ Yes / □ No

If yes, please provide the name of insurance company and policy no.: _____

N.B. If specialist, physiotherapy, chiropractic, dental or hospitalization treatment is required, please also submit Part 2A, 2B or 2C of this Claim Form to be completed by the attending physician or dentist together with photocopy of relevant referral letter.

Declaration and Authorization

(1) I/We declare that the above information is in all respects true and correct to the best of my/our knowledge and belief.

(2) I/We acknowledge and agree that you may:

(a) collect, use and disclose my/our (and my/our dependent's, if applicable) and the claimant's personal information (including but not limited to credit information and claims history) for the purposes necessary to process my/our application, investigate and settle claims and detect and prevent fraud (whether or not relating to the policy issued in respect of this application); and

(b) transfer my/our personal information to the following persons who may collect and use this information only as reasonably necessary to carry out the purposes described above: including, but not limited to insurance adjusters, agents and brokers; employers; health care professionals; hospitals; accountants; financial advisors; solicitors; organisations that consolidate claims and underwriting information for the insurance industry; fraud prevention organisations; other insurance companies (whether directly or through fraud prevention organisation or other persons named in this paragraph); self-regulatory or industry bodies or associations of insurance; claims investigation agencies; the police and databases or registers (and their operators) used by the insurance industry to analyse and check information provided against existing information (collectively, "Such Persons").

(3) I/We further agree that your Policy on Personal Data ("Data Policy"), a copy of which is available upon request or from www.hl-insurance.com, shall apply and my/our personal information may be used, disclosed and/or transferred in accordance with the Data Policy.

(4) I/We hereby authorize any Such Person or any other person or organization that has any records or knowledge of me/us including without limitation my/our health, insurance or claim history to furnish to your company or your authorized representative, any personal data and other information with respect to any medical history (if applicable), insurance or claim history concerning me/us or to any loss, damage, theft or other events connected with my/our insurance or claim history and copies of all relevant records. A photostat copy of this authorization shall be considered as effective and valid as the original. The issue of this claim form does not signify your acceptance of any claim.

(5) I/We declare and confirm that I am / we are duly authorized by the claimant(s) to submit this claim application to you, all information (including personal data) provided to you in this claim application relating to the claimant(s) is collected by lawful means and with the consent of the claimant(s). I/We further confirm that the claimant(s) agree to be bound by the Data Policy and consent to the use and disclosure of their personal data by you for any of the above-mentioned purposes and in accordance with the Data Policy.

Date: _____ Signature of Claimant: _____

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Part 2A – Hospitalization Treatment (To be completed by the Attending Physician)

(a) Name of Patient: _____ HKID Card No.: _____

(b) Name of Hospital: _____

(c) Date of Admission: _____ Date of Discharge: _____

(d) Chief complaints / diagnosis of the patient: _____

_____

(e) Brief discharge summary (including investigative procedures, results, treatments, and/or any complications and follow up plan)

_____

_____

_____

(f) Date and details of surgical procedures carried out, if any: _____

_____

(g) Period of confinement in Intensive Care Unit, if any: _____

(h) Are the symptoms of the patient exclusively due to the accident stated in Part 1 of this claim form? □ Yes / □ No

(i) Was the patient under the influence of intoxicants at the time of accident? □ Yes / □ No

(j) Did the injury of the patient arise out of his / her employment? □ Yes / □ No

(k) Date of first consultation for the symptoms / injury: _____

(l) Name and address of the referral doctor, if any: _____

(m) The extent in percentage of any permanent disability expected as a result of the injury: _____

(n) Nature of such permanent disability, if any: _____

(o) Has the patient ever had the same or similar injury? □ Yes / □ No

(p) Date and details of such previous injury, if any: _____

(q) Name of the attending doctor for such previous injury, if any: _____

I declare that the above information and statements are in all respects true and correct to the best of my knowledge and belief.

_____ _____

Name of Attending Physician (with qualifications) Address

_____

Contact Telephone No.:

_____ _____

Signature of Attending Physician Date

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Part 2B – Specialist, Physiotherapy, Chiropractic Treatment (To be completed by the Attending Physician)

(a) Name of Patient: _____ HKID Card No.: _____

(b) Chief complaints / diagnosis of the patient: _____

_____

(c) Nature and extent of injury: _____

_____

_____

(d) According to the patient, how the injury was caused? _____

_____

_____

(If the injury arose out of his/her employment, please specify.)

(e) Details of investigations, treatment, therapy and surgical procedures done: _____

_____

_____

(f) Future treatment plan: _____

_____

(g) Date of first consultation for the symptoms / injury: _____

(h) Name and address of referral doctor, if any: _____

_____

(i) Was the patient's injury/medical conditions caused by or in anyway associated with the conditions stated below?

1. Any kind of sickness or disease	☐ Yes / ☐ No
2. Surgical operation	☐ Yes / ☐ No
3. More than one traumatic cause	☐ Yes / ☐ No
4. Influence of drug or alcohol	☐ Yes / ☐ No
5. Physical defects/congenital anomally	☐ Yes / ☐ No
6. Degenerative changes	☐ Yes / ☐ No

If yes, please give details: _____

_____

(j) The extent in percentage of any permanent disability expected as a result of the injury: _____
(Medical report detailing the assessment of permanent disability is required.)

I declare that the above information and statements are in all respects true and correct to the best of my knowledge and belief.

Name of Attending Physician (with qualifications)

Address

Contact Telephone No.:

Signature of Attending Physician

Date:

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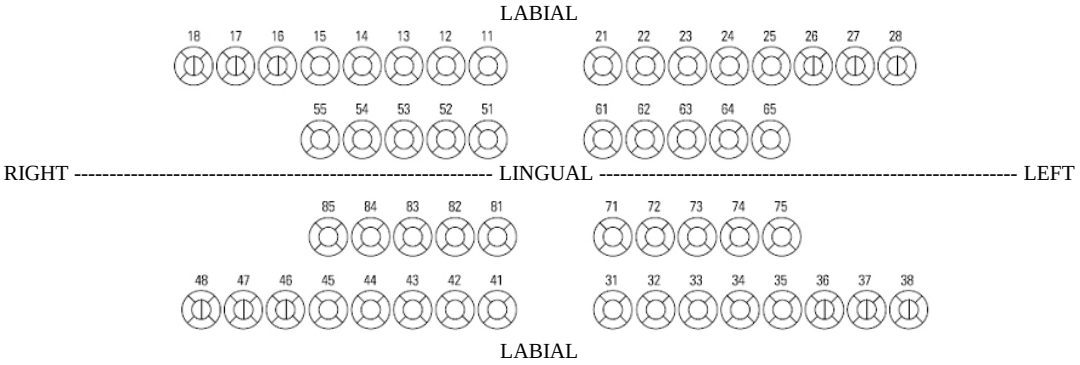
Part 2C – Dental Treatment (To be completed by the Attending Dentist)

(a) Name of Patient: _____ HKID Card No.: _____

Tooth No.	Date	Cause of services	Description of services	Fee

Please mark the treated teeth on the chart below:



(b) Chief complaints / diagnosis of the patient: _____

_____

(c) According to the patient, how the dental injury was caused? _____

_____

(If the injury arose out of his/her employment, please specify.)

(d) In your opinion, was the injury SOLELY caused by the circumstances as stated (c) above? ☐ Yes / ☐ No

If no, please specify the other contributory cause: _____

_____

(e) Date of first consultation for the symptoms / injury: _____

I declare that the above information and statements are in all respects true and correct to the best of my knowledge and belief.

Name of Attending Dentist (with qualifications)

Address

Contact Telephone No.:

Signature of Attending Dentist

Date: