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

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 Policy Holder: _____ Policy No.: _____

Name of Claimant: _____ Relation to the Policy Holder: _____

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

Contact Telephone No.: _____ Email Address: _____

Address: _____

Part 1-To be completed by the Policy Holder

(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 declare that the above information is in all respect true and correct to the best of my knowledge and belief.

(2) I agree that your Personal Data Policy, a copy of which is available upon request or from www.hl-insurance.com shall apply. I understand that: (a) you may use my personal data contained in this form or collected or held by you by any means from time to time for the purposes of the daily operation of the provision of insurance services, direct marketing, researching, designing services or products for me, communicating with me and/or fulfilling any obligations as required by law/regulation from time to time; (b) you may disclose my personal data to any member of the Hong Leong Group and/or any third party (in each case whether within or outside Hong Kong), for any of the above purposes and/or for the purposes of providing administrative and/or other services to you in connection with the operation of your business; (c) I have the right to request access to and the correction of my personal data so held by you. Such request shall be made to your Data Protection Officer. A reasonable fee may be charged by you for processing such request; (d) if I do not wish you to use my personal data in direct marketing or to receive any marketing materials from you, I will notify you of my opt-out in writing addressed to your Data Protection Officer.

(3) I authorize you to provide to and collect information about me (and my dependents, if any) in connection with this Claim Form from any other member of the Hong Leong group or any other organization, institution or person relevant to your business, including other insurance companies, claims investigation agencies, healthcare related entities etc., and to compare such information with my personal data, and to use the results for taking of any actions that may be adverse to my interests.

(4) I authorize any police authority, hospital, clinic, physician, insurance company, service provider or other person or organization that has any records or knowledge of me or my health, insurance or claim history to furnish to your company or your authorized representative, any and all personal data and other information with respect to any illness or injury, medical history, insurance or claim history, consultation prescriptions or treatment and copies of all hospital, medical or other records concerning me. 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.

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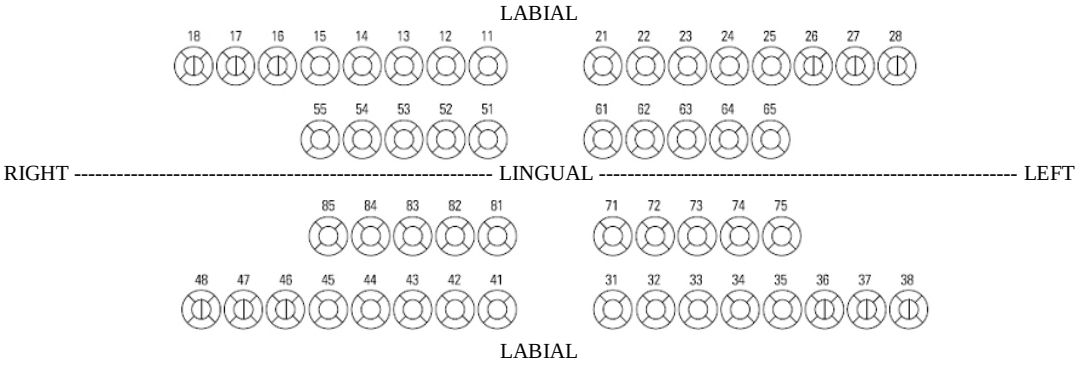
Part 2C – Dental Treatment (To be completed by the Attending Dentist)

(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: