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

DOMESTIC HELPER SERIOUS DISEASE INSURANCE CLAIM FORM

Note: All claims must be reported to Hong Leong Insurance (Asia) Limited within 30 days after the occurrence that gives rise to the claim.

Name of Policyholder: _____ Policy / Certificate No.: _____

Contact Telephone No.: _____ Email Address: _____

Home Address: _____

Name of Helper: _____ Age: _____ Nationality: _____

Commencement Date of Service: _____ Years of Service in Hong Kong: _____

Section 1 – Medical Expenses Cover for Serious Diseases

(1) Signs and symptoms first appeared date and the diagnosed date: _____

(2) Please describe the patient's symptoms or sickness in details: _____

_____

_____

_____

(3) Diagnosis of sickness: _____

_____

(4) Name and address of attending doctor	Date of consultation	Amount incurred
_____	_____	_____
_____	_____	_____
_____	_____	_____

(5) Amount of claim: _____

(6) Do you have any other insurance policies covering the claimed medical expenses: ☐ Yes / ☐ No

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

Note: Please submit all relevant documents such as medical report and medical bills in substantiation of the claim. If hospitalization treatment is required, please also submit Part 2 of this Claim Form to be completed by the attending physician with 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 Policyholder: _____ Signature of Helper: _____

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PART 2 – TO BE COMPLETED BY THE ATTENDING PHYSICIAN　乙部 – 由主診醫生填寫

(1) Name of Patient (in full) 病人姓名(全名) :　　H.K.I.D. Card No. 香港身份證號碼 :

(2) Name of Hospital 醫院名稱 :

Date of Admission 入院日期 : _____　　Date of Discharge 出院日期 : _____

(3) Chief complaints of the patient relating to this hospitalization / surgery 此次住院 / 手術的主要病因 :

(4) Diagnostic investigations / procedures performed 診斷性檢驗 / 程序名稱 :

Final Diagnosis 診斷結果 :

(5) Surgical operation performed 手術名稱 :

Date of Operation 手術日期 :

(6) Brief discharge summary including etiology, treatment, prognosis and any complications and / or follow up plan :
出院撮要包括病因、 治療法、 預後情 況、 任何併發症與及跟進治療方案 :

(7) The date on which the signs and symptoms first appeared or the accident occurred 有關症狀首次出現或意外發生的日期 :

Please state the signs and symptoms 請詳述有 關 症狀 :

(8) The date on which you first attended to the patient for this or similar condition 閣下首次替病人就此或同類病況診治的日期 :

(9) The date on which the patient first received consultation for this or similar condition 病人首次就此或同類病況求診的日期 :

(10) Was this condition a recurrent episode or in anyway associated with a similar condition that the patient had before? If yes, please give details as below:
病人之病況是否再次復發或是與其 過往曾患有的同類病況有關連? 如是，請列出有關資料如下: No 不是 ☐ Yes 是 ☐

Date of Onset 首次病發日期	Name of Attending Doctor 主診醫生姓名	Symptoms and Diagnosis 症狀及診斷結果

(11) Was the patient's condition caused by or in anyway associated with the conditions mentioned below? 病人之病情是否由下列情況所導致或有關連?

(a) Congenital anomalies or deformities 先天異常	No 不是 ☐	Yes 是 ☐
(b) Sterilisation, contraception or treatment relating to birth control 不育、避孕或節育	No 不是 ☐	Yes 是 ☐
(c) Disorders of the mind, psychotic or neurotic 精神錯亂	No 不是 ☐	Yes 是 ☐
(d) Rest cure or sanitary care 休養治療或衛生上的照料	No 不是 ☐	Yes 是 ☐
(e) Drug addiction or alcoholism 酗藥或酗酒	No 不是 ☐	Yes 是 ☐
(f) Cosmetic treatment or plastic surgery 美容或整容手術	No 不是 ☐	Yes 是 ☐
(g) Eye refraction or hearing aids 視力或聽力幫助	No 不是 ☐	Yes 是 ☐
(h) AIDS related, venereal disease or sexually transmitted disease 愛滋病, 性病或由性接觸而傳染的疾病	No 不是 ☐	Yes 是 ☐

If yes, please give details 如是，請詳述:

(12) Was the patient referred by another doctor? If yes, please give details as below:
病人是否經其他醫生轉介? 如是，請列出有關資料如下: No 不是 ☐ Yes 是 ☐

Date of Referral 轉介日期	Name of Referral Doctor 轉介醫生姓名	Address of Referral Doctor 轉介醫生地址

(13) Was the hospitalization medically necessary? If yes, please give reasons as below :
是次入院是否醫療所需? 如是，請詳述原因如下 : No 不是 ☐ Yes 是 ☐

_____
Name of Attending Physician / Specialist (with qualifications)
主診 / 專科醫生的姓名 (資歷)

_____
Signature of Attending Physician / Specialist
主診 / 專科醫生簽名

_____
Address 地址

_____
Telephone 電話

_____
Date 日期