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

eClaim
Scan the QR code to submit claim online

DOMESTIC HELPER 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 3 – Domestic Helper's Medical Expenses (Clinical / Dental Expenses)

(a) Date and time of sickness / accident occurred: _____

(b) Place and full description of the accident: _____

_____

(c) Diagnosis of injury/sickness: _____

(d)

Name and address of attending doctor / dentist / bonesetter	Date of consultation	Amount incurred
_____	_____	_____
_____	_____	_____
_____	_____	_____

(e) Amount of claim: _____

(f) 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.

Declaration and Authorization

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

(2) I acknowledge and agree that you may:
   (a) collect, use and disclose my personal information (including but not limited to credit information and claims history) for the purposes necessary to process my 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 personal information to the following persons who may collect and use this information only as reasonably necessary to carry out the purposes described above: insurance adjusters, agents and brokers; 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), 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 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 personal information may be used, disclosed and/or transferred in accordance with the Data Policy.

(4) I authorize any Such Person or any 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 Policyholder: _____

Declaration and Authorization

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

(2) I acknowledge and agree that you may:
   (a) collect, use and disclose my personal information (including but not limited to credit information and claims history) for the purposes necessary to process my 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 personal information to the following persons who may collect and use this information only as reasonably necessary to carry out the purposes described above: 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), 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 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 personal information may be used, disclosed and/or transferred in accordance with the Data Policy.

(4) I authorize any Such Person or any 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 records or other records concerning me. A photostat copy of this authorization shall be considered as effective and valid as the original.

Date: _____ Signature of Helper: _____