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

eClaim
Scan the QR code to submit claim online

TRAVEL INSURANCE CLAIM FORM

Note: All claims must be reported to Hong Leong Insurance (Asia) Limited within 30 days after returning HKSAR from the journey.

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

Name of Claimant: _____ Relation to the Policyholder: _____

Age: _____ Occupation: _____

Contact Telephone No.: _____ Email Address: _____

Address: _____

Period of Journey: From _____ DD _____ MM _____ YY to _____ DD _____ MM _____ YY

Section 1 – Medical and Other Expenses / Hospital Cash Benefit

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

_____

(b) Full description of the accident: _____

_____

(c) Name and address of independent witness to the accident: _____

_____

(d) Diagnosis of injury/sickness: _____

(e) Name, telephone and address of attending doctor/hospital	Date of visit/Hospitalisation period	Amount incurred
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(f) Nature and amount of claim: _____

(g) Will there be any further medical consultation/treatment required? ☐ Yes / ☐ No

(h) 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, medical bills, boarding pass or entrance and departure record of travel document 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 (and my dependent's, if applicable) 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/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: 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/our 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/us or my/our 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/us. 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: _____