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

eClaim
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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 Policy Holder: _____ Policy/Certificate No.: _____

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

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 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: _____