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

WORKING HOLIDAY 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 Insured: _____ Policy/Certificate No.: _____

Age: _____ Contact Telephone No.: _____ Email Address: _____

Working Holiday Temporary Address: _____

Home Address: _____

Departure Date: _____ DD _____ MM _____ YY Returning Date: _____ DD _____ MM _____ YY

Section 4 – Personal Accident

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

(b) Full description of the accident: _____

_____

_____

_____

_____

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

_____

(d) Nature and extent of injury sustained: _____

(e) Name and address of attending doctor/hospital concerned: _____

_____

(f) Name, address and reference number of the police station concerned: _____

_____

(g) Nature of permanent disability and amount of claim: _____

(h) Do you have any other insurance policies covering the accident? ☐ 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, police report, Working Holiday Visa or relevant documentation, etc in substantiation of the claim.

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 Insured: _____