HL Assurance

Personal Accident / Critical Illness / Hospital Income Claim Form

The acceptance of this Form is NOT an admission of liability on the part of HL Assurance Pte. Ltd.. Any documentary proof or report required by HL Assurance Pte. Ltd. shall be furnished at the expense of the Policyholder or Claimant.

A. PARTICULARS OF POLICYHOLDER / INSURED PERSON / CLAIMANT (COMPANY / INDIVIDUAL)

Name & Address of Policyholder	Policy No.	Period of Insurance
	Tel No.	H/P No.
	E-mail	Name of Intermediary (if any)
	NRIC/Passport No.	
Name & Address of Insured Person / Claimant (if different from Policyholder)	Tel No.	H/P No.
	Date of Birth	Occupation
	E-mail	Date of Employment
	NRIC/Passport No.	Gender: ( ) Male ( ) Female

B. PARTICULARS OF THE LOSS / ACCIDENT / ILLNESS

Date, Time and Place of loss	On when and by whom was the loss discovered	Relationship to Policyholder
Explain fully how did the loss / accident / illness occur	Name & Address of any witnesses of the incident	NRIC/Passport No. Tel No.
	If this loss or occurrence involves Policy Benefits other than Personal Accident	
	Documents to be attached 1. A copy Police Report/Statement 2. Receipts showing date, price, and place of purchase / repair	Claim amount

C. NATURE OF PERSONAL INJURY / CRITICAL ILLNESS

1. Describe in detail the injuries/illness sustained, indicating the part of the body injured and the type of injury/illness (eg. Fracture, cut, bruise, etc.).	
2. Has the same part been injured previously?	( ) Yes ( ) No
3. Name and Address of doctor(s) who treated you and consultation date(s).	
4. Name and Address of your usual family physician.	
5. Details of hospitalization (please attach discharge note & hospital bill): (a) Name of hospital (b) Period of hospitalization	(a) (b) Date Admitted _____ Date Discharged _____
6. Details of Temporary Disability from engaging in or attending to your usual business as a result of the injuries (please attach latest pay slip, medical certificate & medical report): (a) light duties (b) medical leave	(a) From _____ to _____ (b) From _____ to _____
7. Date returned/expected to return to work.	

D. ANY OTHER INSURANCES

1. Is this a job related injury/illness?
   If yes, please attach a copy of the i-report to the Ministry of Manpower.

2. Are you claiming from any other insurance company or other insurance company or other sources in respect of this loss / injury?
   If yes, please state:

Name of Insurance Company	Policy No.	Date Insurance Effected	Amount of Benefits

3. Have you ever made a claim against any other insurers previously? If yes, please state:			
Name of Insurance Company	Date of Accident	Nature of Injury	Amount of Compensation

DECLARATION AND AUTHORISATION

Ver 1.1

1. I/We declare that the above information is true and complete to the best of my knowledge and belief.
2. I/We agree that the Policy shall be void and I/We shall forfeit all rights to recover if I/We have made or were to make any false or fraudulent statements, or withhold material facts whatsoever in respect of this claim.
3. I/We hereby authorise any doctor or any other person, who has ever medically attended to the Insured Person, or any Hospital in which he or she has been treated to disclose any relevant knowledge or information which they acquired, to HL Assurance Pte. Ltd. or their Authorised Representative.
4. I/We hereby request and authorise HL Assurance Pte. Ltd. to pay benefit due in respect of this claim to _____.

Name & Signature of Policyholder _____ Company's stamp (if applicable) _____ Date _____

Name & Signature of Insured Person / Claimant _____ Date _____

Private & Confidential Medical Report

(Note: This Report is to be completed by the Attending Physician / Surgeon)

Name of Patient	NRIC/Passport No.	Date of Birth

1. The nature and extent of injuries (if to a limb, state whether right or left)	
2. Is condition due to injury or sickness?	( ) Sickness ( ) Accident on _____ (DD/MM/YY)
3. Are you the patient's usual Attending Physician? (a) If yes, how long have you know him/her and for what reasons were the medical treatments rendered? (b) If no, was the patient referred to you by another doctor? If so, please furnish Name and Address of referral doctor.	( ) No ( ) Yes (a) (b)
4. (a) Date you first treated the patient (b) Of what symptoms did the patient complain? (c) According to the patient, how long had he/she been experiencing these symptoms?	(a) (b) (c)
5. In your opinion, how long do you feel the symptoms had lasted?	
6. Had the patient previously seen any other doctor or receive treatment on account of these symptoms? If so, please give details.	
7. Has the patient ever experienced any pre-existing condition or symptom at the injured area(s) stated above prior to the accident? If yes, please give details: (i) Nature of pre-existing condition or symptom. (ii) Date on which pre-existing condition/symptom diagnosed. (iii) Cause of the pre-existing condition/symptom.	 (i) (ii) (iii)
7. (a) What was your final diagnosis? (b) Does injury results in fracture of bones? If yes, which part of the body?	(a) (b) ( ) No ( ) Yes - Simple ( ) Fracture Compound ( ) Fracture
8. Did Injury or Sickness require: (a) hospitalization? (b) X-rays? (c) Special diagnostic procedure? (d) Surgery?	 (a) ( ) No ( ) Yes Date Admitted _____ Date Discharged _____ (b) ( ) No ( ) Yes (c) ( ) No ( ) Yes (d) ( ) No ( ) Yes Type of Surgery _____
9. Is patient still under your care for this condition?	(a) ( ) No ( ) Yes
10. Bearing in mind the patient's occupation as stated overleaf, do you feel that the injuries or sickness would have prevented him from working?	
11. How long was or will patient be continuously totally disabled (unable to work)?	
12. How long was or will patient be partially disabled?	
13. Give details of any circumstances, such as intoxication, physical defects or medical history which may have contributed to the accident or sickness and/or lengthen the period of disability.	

I hereby certify that I have personally examined and treated the patient for the above *injury/sickness and that the facts as given above are correct.

Signature of Physician / Surgeon _____ Name and Address of Clinic / Hospital _____

Name and Designation _____ Date _____

BANK ACCOUNT DETAILS	
Name of Account Holder (as per bank account)	Bank Code
Bank Name	Branch Code
Bank Account No.	Swift Code
* Important Notice: The Company shall (i) be discharged from all liability under this claim and (ii) not be liable for any and all losses incurred by you, as a result of you providing the Company with an inaccurate bank account number under this section for the payment of this claim.	

*I/We do solemnly and sincerely declare that the information given is true and correct to the best of my/our knowledge and belief. *I/We understand that any false or fraudulent statements or any attempt to suppress or conceal any material facts shall render the Policy void and we shall forfeit our rights to claim under the Policy.

PERSONAL DATA

In addition to the declaration and authorisation provided above, I/we agree and consent to the Company, its related corporations (collectively, the "Companies"), as well as their respective representatives and agents collecting, using, disclosing and sharing amongst themselves my/our personal data, and disclosing such personal data to the Companies' authorised service providers and relevant third parties for purposes reasonably required by the Companies to evaluate, admit, process and/or administer my/our claims.
These purposes are set out in HL Assurance Pte Ltd Privacy Statement, which is assessable at:
https://www.hlas.com.sg/PolicyOnPersonalData.aspx and which I/we confirm I/we have read and understood.

Ver 1.1