HongLeong Assurance

C012312090

Claim No. : _____ Submission Branch : _____

Agent Who Submits the Claim : _____ Date Customer Informed Agent of the Claim : _____

HOSPITALISATION BENEFIT ON CHILDBIRTH CLAIM APPLICATION FORM

This form is to be completed by the person entitled to the policy monies.

Part I – Particulars of Policy and Life Assured (Event Person)

1. Policy No.:	2. Name:
3. New IC No./Passport No.:	

Part II – Details of Hospitalisation

1. Name of hospital:	2. Address of hospital:
3. Date of admission (dd/mm/yyyy):	4. Date of discharge (dd/mm/yyyy):
5. Date of delivery (dd/mm/yyyy):	6. Type of delivery: Vaginal ☐ Caesarean ☐
7. Name of Gynaecologist / Obstetrician who performed the delivery:	

Part III – Payment instruction on claim monies

1. ☐ By Direct Credit / E-payment.
2. ☐ Utilise claim monies for investment into this Unit Linked Policy. This is subject to Sales and Service Tax (SST) for corporate owned policy. Reinvested amount will follow the existing fund allocation and type. For Level Cover, the Basic Sum Assured shall not be increased by the top up amount.

By default, Hong Leong Assurance Berhad will pay claim monies via Direct Credit / E-payment.

Part IV- Details for Direct Credit / E-payment for Claim Payment

Single owned account is preferred but in the case of jointly owned account, the payee's name has to appear as the first account holder. In the event that you had provided to Claims Department on the bank details earlier but you wish to deposit the claim monies into another bank account, please fill up the Details for Direct Credit / E-payment under Part IV. Otherwise, payment will be made to latest bank account submitted to Claims Department.

1. Name of Payee:	2. Designation/Occupation of Payee:
3. New IC No./Passport No. of Payee:	4. Date of Birth of Payee (dd/mm/yyyy):
5. Payee's Nationality:	6. Payee's Contact No: Email Address:
7. Payee's Residential Address:	8. Payee's Mailing/Correspondence Address:
9. Name of Payee's Bank:	10.Payee's Bank Account Number:

Part V- Particulars of Policy Owner/ Beneficial Owner

1. Details of Policy Owner

1. Name of Policy Owner:	2. New IC No./Passport No.:

2. Details of Beneficial Owner (For Policy Owned By Entity)

a) Entity Name:

b) Entity Registration No.:

In the event of the space provided is insufficient, please provide the information by attaching separate dedaration forms.

	Beneficial Owner 1	Beneficial Owner 2	Beneficial Owner 3
Name			
Designation/Occupation			
New IC No./Passport No.			
Date of Birth (dd/mm/yyyy)			
Nationality			
Contact No.			
Residential Address			
Mailing/Correspondence Address			

Part VI – Declaration and Authorisation

I, the Policy Owner hereby make claim on Hong Leong Assurance Berhad ("the Company") in respect of the policy monies payable on the condition / illness / disability of the Life Assured and / or the benefits due under the above mentioned policy / policies and agree that the written statements, reports and affidavits of any doctor who was consulted by the Life Assured or who attended to the Life Assured and all other documents furnished to the Company in support of this claim shall constitute and are hereby made a part of the proof of the condition / illness / disability of the Life Assured.

2. I declare that the answers and statements given in the daim form submitted herewith are true and complete to the best of my knowledge and belief and that I have not withheld any material fact in my giving of the answers and statements.

3. I acknowledge and agree that the furnishing of this form or of any other form or document to me by the Company for completion, the acceptance of this form or of any other form or document by the Company from me or from any other person, and any act, enquiry or investigation by the Company in connection with or related to the condition / illness / disability of the Life Assured shall not constitute or be considered an admission of any liability by the Company or that there was any cover / assurance in force on the condition / illness / disability of the Life Assured, or that the Company has waived any of its rights or defences.

4. I, the Life Assured hereby authorise any employers, doctors, hospitals, clinics, insurance companies, government offices or any organizations or persons who have any records, knowledge or information, whether medical or otherwise, of myself to disclose to the Company such records, knowledge or information for the purpose of claim considerations.

5. I hereby consent to the deduction of any amount which may be owing by me to the Company, whether under this Policy or any other policy which I may have from the Company, from the amount payable to me in respect of the claim I am now making.

6. A photocopy of this Declaration and Authorisation shall be as valid as the original.

Dated this _____ day of _____

_____
Signature of Witness
Name :
New IC No./Passport No.:
Address :

_____
Signature of Life Assured if Life Assured is not the Policy Owner

_____
Signature of Witness
Name :
New IC No./Passport No.:
Address :

_____
Signature of Policy Owner

Part VII – Claim Requirements

	Requirements	Description
1.	Hospitalisation Benefit on Childbirth Claim Application Form	This form is to be completed by the person entitled to the policy monies.
2.	Birth Certificate**	Original sighted copy of child's birth certificate is required to prove hospitalisation due to childbirth.
3.	Itemised Hospital Bill*	Original sighted copy of itemised hospital bill is required to enable the company to verify the date of admission and date of discharge.
6.	Identity card (for non-foreigner)/ Passport (for foreigner)	a) A photocopy of payee's identity card (for non-foreigner) / passport (for foreigner) for claim payment via Direct Credit / E-payment. b) A photocopy of Policy Owner/ Beneficial Owner's identity card (for non-foreigner) / passport (for foreigner).

Note:

1. *Certification of documents as "Original Sighted" should only be done by either Solicitor, HLA Head Office and Branch Executive / Manager, Agency Manager or Unit Manager. Certification by Unit Manager needs to be countersigned by Agency Manager.
2. **Certification of documents as "Original Sighted" should only be done by either Solicitor, HLA Head Office and Branch Executive / Manager, Agency Manager or Unit Manager.
3. */**Our company reserves the right to call for the original documents if the case warrants the sighting of the original documents during the course of the claim processing.