HongLeong Assurance

C016121020

Claim No. : _____ Submission Branch : _____

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

INVOLUNTARY LOSS OF EMPLOYMENT 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 – Particulars of Life Assured's (Event Person's) Employment Details

1. Name of Employer:	2. Nature of business:
3. Contact No.:	4. Date First Employed (dd/mm/yyyy):
5. Address of Employer:	6. Effective Date of Unemployment/Retrenchment (dd/mm/yyyy):

Part III - 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			

Hong Leong Assurance Berhad 198201014849 (94613-X)
Level 3, Tower B, PJ City Development, No. 15A, Jalan 219, Seksyen 51A, 46100 Petaling Jaya, Selangor.
P.O. Box 120, 46710 Petaling Jaya.
Telephone 03-7650 1818 **Facsimile** 03-7650 1991 **Service Tax ID** W10-1808-32000886
Customer Service Hotline 03-7650 1288 **Customer Service Hotfax** 03-7650 1299
www.hla.com.my

C016122050

Part IV – Declaration and Authorisation

1. I / We, 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 Assured Member / Life Assured and/or the benefits due under Group Policy No. / Policy No. / Policies Nos. _____and agree that the written statements, reports and affidavits of any doctor who was consulted by the Assured Member / Life Assured or who attended to the Assured Member / 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 Assured Member / Life Assured.

2. (For Group Policy Owner only) I / We, the Group Policy owner declare that the Assured Member was eligible for cover under the above Group Policy.

3. I / We declare that the answers and statements given in the claim form submitted herewith are true and complete to the best of my / our knowledge and belief and that I / we have not withheld any material fact in my / our giving of the answers and statements.

4. I / We acknowledge and agree that the furnishing of this form or of any other form or document to me / us by the Company for completion, the acceptance of this form or of any other form or document by the Company from me / us 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 Assured Member / 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 Assured Member / Life Assured, or that the Company has waived any of its rights or defences.

5. I, _____ New IC No./Passport No._____ the *Assured Member / Life Assured / Parent of Life Assured if Life Assured is below age 18 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 _____ New IC No./Passport No. _____ to disclose to the Company such records, knowledge or information for the purpose of claim considerations.

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

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

**delete where applicable.*

Dated this _____ day of _____

_____
Signature of Witness

Name :

New IC No./Passport No.:

Address :

_____
Signature of Parent of Life Assured if Life Assured is below age 18

Name :

New IC No./Passport No.:

_____
Signature of Witness

Name :

New IC No./Passport No.:

Address :

_____
Signature of Assured Member or Life Assured if Life Assured is above age 18 and is not the same person as the Policy Owner

Name :

New IC No./Passport No.:

_____
Signature of Witness

Name :

New IC No./Passport No.:

Address :

_____
Signature of Policy Owner / Group Policy Owner

Name :

New IC No./Passport No.:

Relationship to the Assured Member / Life Assured :

Designation :

(Please affix official stamp)

Part V – Claim Requirements		
	Requirements	**Description**
1.	Involuntary Loss Of Employment Claim Application Form	This form is to be completed by the Policy Owner/Beneficial Owner.
2.	Pay-slips	**Original sighted copies of pay-slips for the past 12 months prior to unemployment/retrenchment must be submitted.
3.	Offer Letter or Appointment Letter by employer	**Original sighted copy of the Offer Letter or Appointment Letter by the employer as proof of employment must be submitted.
4.	Termination Letter/Retrenchment letter	**Original sighted copy of the Termination Letter or Retrenchment Letter by the employer must be submitted.
5.	Birth Certificate/ Identity card (for non-foreigner) / Passport (for foreigner)	*Copy of Policy Owner/ Beneficial Owner's birth certificate or identity card is required to proof the identity of Policy Owner/ Beneficial Owner.

Note:

1. *Certification of documents as "Original Sighted" should only be done by either 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 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.