HongLeong Assurance

C012813030

Claim No. : _____ Submission Branch : _____

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

LIVING CLAIM APPLICATION FORM

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

Part I – Particulars of Policy

1. Policy No.:	2. Sum Assured:

Part II – Particulars of Assured Member / Life Assured (Event Person)

1. Name:	2. New IC No./Passport No.:
3. Date first employed (dd/mm/yyyy):	4. Date last attended work (dd/mm/yyyy):
5. Exact duties performed:	
6. Contact No.:	7. Email Address:
8. Name of Employer:	9. Contact No. of Employer:
10. Address of Employer:	

Part III – Particulars of Education and Income (Applicable only for Total and Permanent Disability Claim)

1. Please state highest level of formal education completed:	
2. Was there any income received after disability? If yes, please state the source of income:	
3. Please state the average monthly income:	4. Please state the date when income expected to cease (dd/mm/yyyy):

Part IV – Particulars of The Illness / Disability

1. Nature of illness / disability:	2. Date of diagnosis (dd/mm/yyyy):
3. Symptom(s) of illness / disability:	4. Date symptom(s) first noted (dd/mm/yyyy):
5. Date of disability started (dd/mm/yyyy):	
6. If disability was caused by accident, please give: a) Date and time of accident (dd/mm/yyyy): am / pm	b) Detailed circumstances of the accident:

Hong Leong Assurance Berhad 198201014849 (94613-X)
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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

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Part V – Particulars on Doctors Consulted

	First Treatment Date (dd/mm/yyyy)	Name and Address of Doctor(s)
1. First doctor consulted for this illness / disability.		
2. All other doctors consulted for this illness / disability.		
3. Regular doctors / gynaecologist / obstetrician.		
4. All other doctors consulted in the past five (5) years.		

Part VI – Particulars on Past Medical History

	Date of Diagnosis/ Onset (dd/mm/yyyy)	Name & Address of Doctor(s) Consulted	Dates of Consultation (dd/mm/yyyy)
1. Hypertension.			
2. Diabetes Mellitus.			
3. Cardiovascular Disease.			
4. Other Illnesses / Injuries. Please specify: a) b)	a) b)	a) b)	a) b)

Part VII – Particulars on Other Policy / Policies

Name of Insurance Company	Policy No.	Policy Effective Date (dd/mm/yyyy)	Sum Assured

Part VIII – Method of Claim Payment

1. ☐ By Direct Credit / E-payment.

2. ☐ Utilise claim amount for reinvestment 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 amount via Direct Credit / E-payment.

Part IX- 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 IX. 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 X – Particulars on Assured Member / Employee (Applicable only for Non-Employee Benefits Group Term Life and Employee Benefits)

1. Assured Member / Employee Name:	2. New IC No./Passport No.:
3. Date first eligible for cover (dd/mm/yyyy):	4. Position held: Job Grade:

5. Dates of all medical leaves taken in the past one year prior to the illness / disability.

Date (dd/mm/yyyy)	Duration	Type of Sickness / Extent of Injuries Sustained

6. Was the Assured Member / Employee on prolonged illness leave prior to or due to the illness / disability?

Yes ☐ If yes, please provide the particulars and supporting documents:

No ☐

Prolonged Illness Leave	Date (dd/mm/yyyy)		Type of Sickness / Extent of Injuries Sustained
	From	Till	
Full-pay leave			
Half-pay leave			
No-pay leave			

7. Was the Assured Member / Employee medically boarded out?

Yes ☐ Date (dd/mm/yyyy):
If yes, please provide the supporting documents.

No ☐

Part XI – Particulars on Coverage Effective Date, Loan Credit Amount and Other Group Schemes (Applicable only for Claim on Mortgage Decreasing Term Assurance, Overdraft, Credit Card, Fixed Deposit Scheme or Other Financial Institution Scheme e.g. Unit Trust and Edusave)

1. Date first eligible for cover (dd/mm/yyyy):	2. Amount of loan approved (If applicable):

3. Exact outstanding or balance amount as at date of illness / disability (loan, fixed deposit, unit trust etc.):

4. Exact outstanding or balance amount as to date (loan, fixed deposit, unit trust etc.):

Part XII- 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 declaration 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 XIII – 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 XIV – Claim Requirements							
	Requirements	**Dread Disease Claim**	**Old Age Disablement Claim / Total Permanent Disability Claim**	**Congenital Anomalies Claim**	**Facial Reconstructive Surgery Claim**	**Pregnancy Care or Pregnancy Complication Claim**	**5 Senses Claim**
1.	Living Claim Application Form a) This form is to be completed by the person entitled to the policy monies.	✓	✓	✓	✓	✓	✓
2.	Medical Attendant's Report This report must be completed by a registered qualified physician at the claimant's own expense.	✓	✓	✓	✓	✓	✓
3.	Original Policy Contract / Deed of Assignment / Assurance Certificate Original Policy Contract / Deed of Assignment / Assurance Certificate must be returned to the Company. In the event that the original copy is lost, a statutory declaration for lost must be declared and signed before a Commissioner for Oaths.	✓	✓	✓	✓	✓	✓
4.	Other Supporting Documents to prove the eligibility of cover for Non-Employee Benefits type of Group Term Life Policy and Other Financial Institution Group Policy. a) For Non-Employee Benefits type of Group Term Life Policy, proof of membership is required. b) For Other Financial Institution Group Policy, please submit the requirements as follows: i. Fixed Deposit Listing or Deposit Receipt(s) on Fixed Deposit Life Scheme. ii. Loan Agreement and Credit Card Statement on Credit Card Scheme or Overdraft Scheme to confirm the outstanding loan or credit amount at date of disability. iii. Investment Listing on Unit Trust Group Policy.	✓	✓				
5.	Appointment letter* / Payslips* (Applicable only for Employee Benefits policy) Original sighted copy of last two (2) months' Payslips and Appointment Letter must be submitted.	✓	✓				
6.	Police Report* Original sighted copy of the police report is required if the cause of disability was due to accident and if a report has been lodged to the police.	✓	✓		✓		✓
7.	Laboratory / Test Report(s)* Original sighted copies of any laboratory / test reports must be submitted if investigation has been carried out to confirm the diagnosis.	✓	✓	✓	✓	✓	✓
8.	Birth Certificate / Identity Card (for non-foreigner) / Passport (for foreigner) Original sighted copy of the Assured Member / Life Assured (event person)'s birth certificate** / identity card (for non-foreigner)** / passport (for foreigner)** is required to prove the identity of Assured Member / Life Assured (event person).	✓	✓	✓	✓	✓	✓

	Requirements	Dread Disease Claim	Old Age Disablement Claim / Total Permanent Disability Claim	Congenital Anomalies Claim	Facial Reconstructive Surgery Claim	Pregnancy Care or Pregnancy Complication Claim	5 Senses Claim
9.	Patient Card A photocopy of Assured Member / Life Assured's (event person)'s patient card is required to facilitate extraction of medical reports by hospitals / clinics.	✓	✓	✓	✓	✓	✓
10.	Original sighted copy of payee's identity card (for non-foreigner) / passport (for foreigner).	✓	✓	✓	✓	✓	✓
11.	Photocopy of itemised In-patient Bills and Receipt				✓		✓
12.	Original sighted copy 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.