HL Assurance
A Member of the Hong Leong Group

Domestic Maid Claim Form

Please state as fully and accurately as possible the information asked for below and to return this form immediately to HL Assurance Pte. Ltd. ("Company") with original final bills/receipts. The acceptance of this form is not in itself an admission of liability on the part of the Company.

PARTICULARS OF POLICYHOLDER / INSURED		
Name of Policyholder / Insured	NRIC No.	Policy No.
Address	Gender: Male / Female	Contact No.
PARTICULARS OF CLAIMANT		
Name of Claimant	Fin No. / Passport No.	Nationality
Date of Employment	Monthly Salary	Monthly Levy
DETAILS OF SICKNESS		
Describe nature of sickness	Date First Began	Date First Treated
Has the sickness been treated previously? ☐ Yes ☐ No If yes, please state date of previous treatment		
Is the sickness due to pregnancy, abortion, sterilization or infertility? ☐ Yes ☐ No If yes, please specify condition & date of commencement.		
DETAILS OF INJURY		
Date of Accident	Time of Accident	Is this a job related accident? ☐ Yes ☐ No
Describe how & where the accident occurred		

OTHER INFORMATION		
Name of Hospital / Clinic	Address of Hospital / Clinic	Name of Attending Doctor
Date of Admission	Date of Surgery performed	Date of Discharge
Is the patient entitled to claim for this treatment against any other insurance policies? If yes, please indicate the name of the insurance company and details of insurance.		

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.

AUTHORISATION

Without prejudice to the consent given below in respect of my/our personal data, I/we hereby authorize any hospital, physician or other person who has attended or examined me/us, to furnish to the Company or its authorized representatives, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A copy of this authorization shall be considered as effective and valid as the original.

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 in collecting, using, disclosing and sharing amongst themselves my/our personal data, and disclosing such personal data to the Companies' authorized 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 accessible at https://www.hlas.com.sg/PolicyOnPersonalData.aspx and which I/we confirm I/we have read and understood.

Name of Policyholder _____ Signature of Policyholder _____
(Please affix company stamp if applicable)

Name of Claimant _____ Signature of Claimant_____

Date _____

N.B. No claim can be admitted unless medical certificate from a duly qualified and registered medical practitioner on the form below be furnished at the expense of the Insured.

ATTENDING DOCTOR'S STATEMENT

1. Name of Patient	2. Fin No./Passport No	3. Date Of Birth

4. (a) If Injury: When did accident occur?	(a)
(b) If Sickness: When did symptoms first appear?	(b)

5 (a) State the nature of injury or sickness
(Describe complications – If Any)

(b) Final Diagnosis

(c) Nature of Surgery (if any)

6 (a) When did the Patient first receive medical attention for this condition?

(b) Name of the Registered Medical Practitioner

(c) Address of the Registered Medical Practitioner

7. Has the Patient ever had this or any similar medical condition? ☐ Yes ☐ No
If yes, please provide details:

8. Is the present condition of patient due to:

(a)	Congenital anomaly?	☐ Yes	☐ No
(b)	Nervous or mental disorder?	☐ Yes	☐ No
(c)	Pregnancy/childbirth/infertility?	☐ Yes	☐ No
(d)	Alcohol influence?	☐ Yes	☐ No

If your answer is yes to any of the above, please provide details:

(a) _____
(b) _____
(c) _____
(d) _____

9. Period of Hospitalisation
Date of Admission:
Date of Discharge:

10. Name of Hospital Admitted:

Address of Hospital Admitted:

11. Are you the Patient's usual Doctor? ☐ Yes ☐ No If No, please provide name and address of usual doctor?
I hereby certify that I have personally examined and treated the patient for the above injury/sickness and that the facts as given above present my opinion of his/her medical condition. Name of Doctor: _____ Date: _____ _____ Signature & Official Stamp of Doctor