



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. I/C No.: (new) (old)	4. Contact No.: Fax No.:
5. Email Address:	6. Address:

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. I/C No.: (new) (old)
3. Contact No.: Fax No.:	4. Email Address:
5. Address:	

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			
I/C No./ Passport No.			
Contact No.			
Designation			
Correspondence Address			



3. Politically Exposed Person (PEP) Declaration

Notes:

1. All names as per NRIC/Passport.
2. Politically Exposed Persons (PEP)
 - a) are individuals who are or who have been entrusted with prominent public function (Head of State or Government, senior politicians, senior government, judiciary or military officials, senior executives of state owned corporations and important political party officials)
 - b) persons who are or have been entrusted with a prominent functions by an international organization which refers to members of senior management. (Directors, deputy directors and members of the board or equivalent functions)
3. Family Members and Close Associates
 - a) Family Members
 - are individuals who are related to a PEP either directly (consanguinity) or through marriage. This includes parents*, siblings*, spouse (s), child* or spouse’s parents*.(*biological and non biological relationship)
 - b) Close Associates
 - any individual closely connected to a PEP, either socially or professionally and may include extended family members such as relatives(biological or non biological relationship), financially dependent individuals (persons salaried by the PEP such as drivers, bodyguard, secretaries, business partners or associate, prominent members of the same organization as the PEP, individuals working closely with the PEP ie.work colleagues, close friend)
4. Beneficial Owner
 - Refers to any natural person(s) who ultimately owns or controls a customer and/or the natural person on whose behalf a transaction is being conducted. It also includes those natural persons who exercise ultimate effective control over a legal person or arrangement. Reference to “ultimately owns or control” or “ultimate effective control” refers to situations in which ownership or control is exercised through a chain of ownership or by means of control other than direct control. This also refers to any natural person(s) who ultimately owns or controls a beneficiary, where specified in this document.

Please tick (✓) the appropriate box

1. Does Policy Owner or any Beneficial Owner(s) as stated in Section 1 and 2 of Part V hold, or has previously held or is being considered for a prominent public position?
 Yes No

If yes, please elaborate:

Name of Policy Owner or beneficial owner(s)	Position Held	No. of Years

2. Does any of the Policy Owner or Beneficial Owner(s)’s immediate Family Members/Close Associates hold, or previously held or is being considered for prominent public position?
 Yes No

If yes, please elaborate:

Name of Policy Owner or Beneficial Owner(s)	Details of Immediate Family Members/Close Associates			
	Name	I/C No./ Passport No.	Position Held	Relationship to Policy Owner or Beneficial Owner(s)

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, _____ I/C No. (New) _____ (Old) _____ 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 _____ Birth Certificate No. _____ or I/C. No. (New) _____ 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 :

I/C No. :

Address :

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

Name :

I/C No. :

Signature of Witness

Name :

I/C 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 :

I/C No. :

Signature of Witness

Name :

I/C No. :

Address :

**Signature of Policy Owner / Group Policy Owner

Name :

I/C No. :

Relationship to the Assured Member / Life Assured :

Designation :

(Please affix official stamp)

** Mandatory to be completed, signed and witnessed.

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:

- *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.
- **Certification of documents as “Original Sighted” should only be done by either HLA Head Office and Branch Executive / Manager, Agency Manager or Unit Manager.
- 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.