HongLeong Assurance

C015117090

Claim No. : _____

Agent Who Submits the Claim : _____

Submission Branch : _____

Date Customer Informed Agent of the Claim : _____

ADVANCED CANCER CARE 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. Occupation:
7. Address:	

Part II – Particulars of Life Assured's (Event Person's) Employment Details

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

Part III – Particulars of The Illness / Disability

1. Nature of illness / disability:	2. Date of diagnosis (dd/mm/yyyy):
3. Date symptom(s) first noted (dd/mm/yyyy):	4. Duration of symptom(s):
5. Symptom(s) of illness / disability:	6. Name of hospital sought treatment:

Part IV – Particulars on Doctors Consulted

	Consultation / 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.		
4. All other doctors consulted in the past five (5) years.		

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

Part V – 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 VI – Particulars on Other Policy / Policies

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

Part VII- 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
   is 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 VII 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 VIII – 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 Policy No. / Policies Nos. _____ 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 Life Assured.

2. I declare that the answers and statements given in the claim 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, _____ I/C No. (New) _____ (Old) _____ the **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.

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 :

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 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

Name :

I/C No. :

Relationship to the Life Assured:

** Mandatory to be completed, signed and witnessed.

Part IX – Claim Requirements		
	Requirements	**Hospital & Surgical Benefit**
1.	Global Cancer Care Claim Application Form This form is to be completed by the person entitled to the policy monies.	✓
2.	Medical Attendant's Report on Global Cancer Care This report must be completed by a registered medical practitioner at the Claimant's own expenses.	✓
3.	Birth Certificate / Identity Card (for non-foreigner) / Passport (for foreigner) A photocopy of event person's birth certificate, identity card (for non-foreigner) / passport (for foreigner) is required to prove event person's age if the age has not been admitted at time of insurance application.	✓
4.	Patient Card A photocopy of event person's patient card is required to facilitate extraction of medical reports by hospitals / clinics.	✓
5.	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.	✓

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. 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.