



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.

SECTION A - INSURED'S DETAILS		
Name of Insured	NRIC No	Policy No
Address	Gender: Male/Female	Contact No.
SECTION B - INSURED PERSON'S DETAILS		
Name of Insured Person	Fin/Passport No	Nationality
Date of Employment	Monthly Salary	Monthly Levy
SECTION C - SICKNESS		
Describe nature of sickness	Date First Began	Date First Treated
Has the sickness been treated previously? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state date of previous treatment		
Is the sickness due to pregnancy, abortion, sterilization or infertility? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify condition & appropriate date of commencement.		
SECTION D - INJURY		
Date of Accident	Time of Accident	Is this a job related accident? <input type="checkbox"/> Yes <input type="checkbox"/> No
Describe How & Where Accident Happened		
SECTION E - 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 (eg. Type, policy no.etc)		

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.	

DECLARATION AND AUTHORISATION

I/We hereby declare that the particulars stated above are true and correct in every detail and I/we agree that if I/we have made or in any further declaration in respect of the same claim shall make any false or fraudulent statements or suppress conceal or falsely state any material fact whatsoever the relevant insurance policies shall be void and all rights to recover thereunder in respect of past or future claims shall be forfeited.

Without prejudice to the consent given below in respect of my/our personal data, I/we hereby authorize any hospital physician, 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 authorization provided above, I/we agree and consent to the Company, its related corporations (collectively, the "Companies"), as well as their respective representatives and agents 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 assessable at: <https://www.hlas.com.sg/PolicyOnPersonalData.aspx> and which I/we confirm I/we have read and understood.

Insured Person's Signature / Date

Insured's Signature / 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.

SECTION F – ATTENDING DOCTOR'S STATEMENT		
1. Name of Patient	2. Fin/Passport No	3. Date Of Birth
4. (a) If Injury: When did Accident occur? (b) If Sickness: When did symptoms first appear?	(a) (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? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, please provide details:		
8. Is the present condition of patient due to:		
(a) Congenital anomaly?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
(b) Nervous or mental disorder?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
(c) Pregnancy/childbirth/infertility?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
(d) Alcohol influence?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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?

No

Yes

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:

Dated:

Signature & Official Stamp of Doctor