ACCIDENTAL & HEALTH CLAIM FORM

INSTRUCTIONS:

1. You fully complete Sections 1 – 7 of the claim form including either the illness or injury statement. We cannot proceed with the claim without this information.

2. Ensure you sign the privacy declaration (Section 10)

3. **THE POLICYHOLDER or YOUR EMPLOYER** fully completes Section 8 of the claim form.

4. **YOUR DOCTOR** fully completes the Section 9 under "Medical Practitioners Statement"

6. Scan and email the claim form through to newclaims.ca@hdi.global

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SECTION 1 — POLICY & INSURED DETAILS

Policyholder Name: _____
Policy Number: _____
Claim Number (if any): _____

Employer / Organization Name: _____
Business Unit / Department: _____

Insured Person Details

- Title: ☐ Mr ☐ Ms ☐ Mrs ☐ Dr
- Full Name: _____
- Date of Birth (DD/MM/YYYY): _____
- Gender: ☐ Male ☐ Female ☐ Other
- Country of Residence: _____
- Occupation / Job Title: _____

Contact Information

- Residential Address: _____
- City / Province / Postal Code: _____
- Mobile Phone: _____
- Email Address: _____

☐ I consent to communication by email

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SECTION 2 — CLAIM TYPE (Tick all that apply)

☐ Accidental Injury
☐ Illness / Sickness
☐ Outpatient Medical Expenses
☐ Hospitalization
☐ Income Loss / Disability
☐ Travel-related Medical Claim

SECTION 3 — INCIDENT / ILLNESS DETAILS

Date of Accident / Onset of Illness: ___ / ___ / _____
Time (if accident): _____ AM / PM

Location of Incident / Treatment:

Nature of Claim ☐ Accident ☐ Illness

Detailed Description (mandatory):
(Explain clearly *how*, *where*, and *why* the injury/illness occurred)

_____

_____

_____

Were there any witnesses? ☐ Yes ☐ No
If yes, Name & Contact: _____

Was the incident work-related or during official travel?
☐ Yes ☐ No

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SECTION 4 — MEDICAL INFORMATION

Diagnosis / Injury Description:

_____

_____

_____

Date of First Medical Consultation: ___ / ___ / _____

Treating Doctor / Hospital / Clinic

- Name: _____
- Address: _____
- Country of Treatment: _____

Hospitalization Required? ☐ Yes ☐ No
If yes:

- Admission Date: ___ / ___ / _____
- Discharge Date: ___ / ___ / _____

Have you had this condition previously? ☐ Yes ☐ No
If yes, provide details:

_____

_____

_____

_____

_____

SECTION 5 — MEDICAL EXPENSE DETAILS

(Attach invoices, receipts, prescriptions)

Date	Description of Treatment	Provider	Currency	Amount

Total Amount Claimed: _____

Were any expenses reimbursed by Government Health Insurance or Group Benefits plan?

☐ Yes ☐ No

If yes, attach statements.

SECTION 6 — INCOME LOSS / DISABILITY (If Applicable)

Date work ceased due to injury/illness: ___ / ___ / _____

Current Work Status ☐ Fully Disabled

☐ Partially Disabled

☐ Returned to Work (Date: ___ / ___ / _____)

Is the disability related to:

☐ Accident ☐ Illness

Have you claimed benefits elsewhere (Workers Comp, other insurance)?

☐ Yes ☐ No

If yes, details: _____

_____

SECTION 7 — BANK DETAILS (For Reimbursement)

- Account Holder Name: _____
- Bank Name: _____
- Branch / BSB / Sort Code: _____
- Account Number / IBAN: _____
- SWIFT Code: _____
- Currency for Payment: _____

SECTION 8 — POLICYHOLDER DECLARATION

Claimant is an Insured Person on the policy? ☐ Yes ☐ No

(Required for income loss claims)

This is to certify that the above-named employee has been unable to work due to injury/illness.

- Employment Start Date: ___ / ___ / _____
- Type of Employment: ☐ Full-Time ☐ Part-Time ☐ Contract
- Average Gross Salary: _____

Policyholder Representative

- Name: _____
- Designation: _____
- Signature: _____ Date: _____

SECTION 9 — MEDICAL PRACTITIONER STATEMENT

(To be completed by treating doctor)

- Diagnosis: _____
- Treatment Provided: _____

- Period of Disability (if any): _____
- Doctor's Name & Qualification: _____
- Clinic / Hospital Stamp & Signature: _____
- Date: _____

SECTION 10 — DECLARATION & AUTHORITY

I declare that the information provided in this claim form is **true, complete, and correct**, and that no material facts have been withheld.

I authorize the insurer and its representatives to obtain medical, employment, and insurance information relevant to this claim.

Claimant Name: _____
Signature: _____ Date: _____

Witness Name: _____
Witness Signature: _____ Date: _____

✅ **ATTACHMENT CHECKLIST**

☐ Medical reports
☐ Original invoices & receipts
☐ Prescriptions
☐ Hospital discharge summary (if any)
☐ Employer verification (if income claim)
☐ Doctor's statement
☐ ID / Insurance card copy

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