LONPAC INSURANCE BHD

STUDENTS' ACCIDENT PROTECTION SCHEME - CLAIM FORM

1. Claim Number:	2. Date Reported:
3. Name of Institution/School:	
4. Policy Number:	5. Expiry Date:
6. Name of Insured Person:	7. Class:
8. Address:	
9. Contact Numbers:	10. Email:
11. Date/Time of Accident:	
12. Place of Accident:	
13. Brief Description of Accident:	
14. Nature of injury *(Please indicate 'left' or 'right' and the type of injury e.g. left elbow fractured)*:	
15. Name of Clinic/Hospital where treatment was sought:	
16. Are you claiming under any other policy in respect of this accident? YES/NO. If 'YES', please give details. Name of Insurer:	Policy Number:
17. Medical/Hospital/Surgical expenses incurred: Cash:	CPF:
18. Claim cheque to be made in favour of (IN BLOCK LETTERS – Name indicated must be a bank account holder): Address of Payee (if different from above):	
19. Are you fully recovered from your injury? YES/NO. If 'NO', please advise follow-up actions and/or next appointment date. *(Kindly send/fax the claim to us first, accumulate all the bills and then submit to us after the final checkup.)*	

Please Turn Overleaf

OCT 2015

DATA PRIVACY STATEMENT AND DECLARATION

In accordance with the Personal Data Protection Act 2012, I/We consent to the collection, use, disclosure of and/or process my/our personal data (whether contained in the Claim Form or otherwise obtained) by Lonpac Insurance Bhd ("Lonpac"), its affiliates and service providers (within or outside Singapore), for the purpose relating to the evaluation of the claim and to provide advice and information relating to the claim to me/us by Short Message Service (SMS), Multimedia Messaging Service (MMS) and fax messages (notwithstanding the registration of my/our telephone number(s) in the Singapore's Do Not Call Registry). For more information on our Privacy Policy, please visit our website http://www.lonpac.com.sg/web/sg/privacy_policy.

I/we have read and agreed to the above Data Privacy Statement.

_____

(Signature of Claimant/Parent/School Representative)

Name of Claimant/Parent: _____

NRIC/Passport No.: _____

Kindly send all the **ORIGINAL** medical bills and receipts by 'Registered post' to:

AB LIM PTE LTD
Blk 123 Bukit Merah Lane 1 #04-78 Singapore 150123
Tel: 62722277 Fax: 62727567
Email: claims@ablim.com.sg
Operating Hours: 9.30 am to 12.30 pm & 2.30 pm to 5.00 pm (Monday to Friday excluding Public Holiday)

NOTE: This form is issued without admission of liability and it must be completed and returned to us immediately whether or not claim is made.