CLAIM FORM

This form must be completed truthfully and accurately. The submission of an incomplete form or insufficient information or supporting documents may delay the processing or result in the denial of your claim.

Policy No.	Name of Policyholder	Occupation (Rank)

Personal Details of Insured Person		
Mobile Phone No.	Name of Insured Person	
Other Contact No.	E-mail address (for correspondence)	Date of Birth (*dd/mm/yyyy*)
Correspondence Address		

Type of Claim		
□ Income Protection	□ Personal Accident	□ Critical Illness

Claim Details		
Date of Accident/Diagnosis (*dd/mm/yyyy*)	Date of First Consultation for treatment (*dd/mm/yyyy*)	Date last reported to work (*dd/mm/yyyy*)
Circumstance of Loss (Briefly describe how injury was incurred due to accident or describe symptoms appeared if sickness)		
Nature of Injury / Diagnosis of Sickness * Please refer to checklist and provide supporting documents.		

Declaration & Authorization

PLEASE READ CAREFULLY BEFORE SIGNING:

The undersigned hereby declares that to the best of my/our knowledge and belief, the above statement and particulars are fully and truly made;

I/We agree that if any fraudulent means or devices are used in connection with obtaining any benefit under the Policy, the Policy shall be void against me/us;

I/We agree that any of my/our personal information collected or held by Starr International Insurance (Asia) Limited ("STARR") or its authorized representatives is provided and be held, used and disclosed by STARR to individuals/organization associated with STARR or any selected third party for the purpose of processing the claims herein, providing data matching and to communicate with me/us for such purposes. The undersigned understand that STARR may not be able to process the claims herein if I/we fail to provide any information requested in this Claim Form. The undersigned further understand that I/we have the right to obtain access and to request correction of my personal information held by STARR. Such request can be made to STARR's Operations Services Manager at Suite 1901, 19/F Central Plaza, 18 Harbour Road, Wanchai, Hong Kong.

I/We hereby irrevocably authorize STARR or its authorize representative to obtain my/our medical records from my/our treating physicians, hospitals, clinics, insurance companies, government agencies or other relevant organizations and my employment/membership records from my previous and current employer/policyholder in relation to the accident or claim. This authorization is valid even I/we am/are deceased. My/our next of kin is also bound by this authorization. The original or copy of this authorization has the same effects.

Printed Name of Policyholder	Signature
Date Signed (*dd/mm/yyyy*)	

IMPORTANT REMINDER:
Please refer to the Document Checklist for the list of documents needed to support your claim. We reserve the right to request for additional information &/or additional documents if we may find necessary.

Starr International Insurance (Asia) Limited
Suite 1901, 19/F Central Plaza, 18 Harbour Road, Wanchai, Hong Kong
Phone: (852) 3765 5401
Email: TopCoverClaim@starrcompanies.com