Berkshire Hathaway Specialty Insurance

Accident & Health

EXPATRIATE INSURANCE CLAIM FORM

INSTRUCTIONS:

Please complete the sections of the claim form relevant to the claim you wish to make.

1. If you/the Insured Person suffers an **accident** outside your country of residence which results in **bodily injury** and you wish to make a claim for:

   (a) Disablement benefit;
   (b) Weekly injury benefit; or
   (c) Fractured bones benefit;
   please complete Parts 1, 2 and 3 of this form.

2. Please also complete Parts 1, 2 and 3 of this form if you/the Insured Person suffer **sickness** outside your currency and wish to make a claim for weekly sickness benefit.

   Part 1 of the claim form needs to be completed by the Policyholder or the employer of the Insured Person making the claim. Part 2 of the claim form needs to be completed by the Insured Person making the claim. Part 3 of the claim form needs to be completed by the attending doctor.

   ***Note**: If you incur medical expenses but do not wish to make a claim for the benefits outlined above, you need only complete Part 4 of the claim form.*

3. If you/the Insured Person wish to make a claim for any other benefits available under the Expatriate Medical Insurance Cover, please complete Part 4 of the claim form.

IMPORTANT NOTES:

1. It is very important that all relevant sections of the policy are completed as fully and as accurately as possible and that supporting documentation is provided with the claim. For details of the documentation and information typically required in support of a claim please see our website:

   https://www.bhspecialty.com/claims/claims-macau/ah-claims-guide.

   Copy/scanned documents may be provided although we reserve the right to ask for original documentation. We also reserve the right to ask for documents and information in addition to that which you submit with your claim form.

   If in any doubt as to the information or documentation required for your claims submission please contact our claims team (details below).

2. Each claim will be reviewed and assessed on its own merits and all settlement decisions shall be determined according to the terms and conditions of your Policy.
3. Acceptance by BHSI of your claims submission does not represent an admission of policy liability on the part of BHSI.
4. Claims settlement and payment shall be made in accordance with the relevant policy terms and conditions.

CLAIMS SUBMISSION AND ENQUIRY:

All claims submissions and enquiries may be sent to BHSI using the email address below:
AsiaAHclaims@BHspecialty.com

Should you wish to mail your claim to BHSI, our address in Macau is below:

Berkshire Hathaway Specialty Insurance
Av. Do Infante D. Henrique No 47
The Macau Square 14-C
Macau

If you wish to speak to our claims team for assistance before submitting your claim please call +853 0800646.

PART 1

(To be completed by the Policyholder)

Policy Number:

A. POLICYHOLDER/INSURED PERSON DETAILS

Name of Policyholder: _____

Name of Insured Person: _____

Date of Birth: _____ (DD/MM/YYYY) Sex: ☐ Male ☐ Female

Macau ID /Passport No.: _____ Nationality: _____

Country of Residence: _____ Country of Assignment: _____

Occupation: _____

Effective Date of Employment: _____ (DD/MM/YYYY) Effective Date of Insurance: _____ (DD/MM/YYYY)

Monthly Income details for 6 months prior to disability:

List duties performed at work:

B. ACCIDENTAL DEATH OF THE INSURED PERSON

Was the Insured Person fatally injured as a result of an accident? ☐ Yes ☐ No

If you have answered yes, please sign and submit this Part 1 to BHSI together with supporting documentation. A list of documents and information to be submitted with the claim can be found on our website https://www.bhspecialty.com/claims/claims-macau/ah-claims-guide. On receipt of the claim we will provide further advice and assistance.

If you have answered no, please proceed to complete the sections below. The Insured Person will also need to complete Parts 2, 3 and/or 4."

C. DISABILITY/EMPLOYMENT STATUS OF EMPLOYEE/INSURED PERSON

1. Describe the bodily injury or sickness giving rise to the claim:

If bodily injury, did it result from an accident? ☐ Yes ☐ No

2. When and where did the Employee/Insured Person suffer the sickness/bodily injury? _____ (DD/MM/YYYY)

Country: _____ Location: _____

3. When was the Employee/Insured Person first absent from work? _____ (DD/MM/YYYY)

4. Is the Employee/Insured Person currently on any medical/unpaid leave? ☐ Yes ☐ No

If Yes, please advise the following and furnish copies of the medical certificates and unpaid leave notification.

Medical Leave from: _____ (DD/MM/YYYY) to _____ (DD/MM/YYYY)

Unpaid Leave from: _____ (DD/MM/YYYY) to _____ (DD/MM/YYYY)

5. If the Insured Person was involved in an accident, was it work related? ☐ Yes ☐ No

If yes, please provide the following details:

A) Date/Time of the accident: _____
(DD/MM/YYYY)

B) Location of the accident: _____

C) Description of the circumstances surrounding the accident:

_____

D) Are you submitting a claim to your employee's compensation insurer? ☐ Yes ☐ No

If yes, please provide:

(i) the name and address of your employee's compensation insurer:

Name: _____

Address: _____

(ii) the policy number: _____

(iii) the value of the claim submitted to the insurer: _____

E) Was the accident reported to the Police? ☐ Yes ☐ No

If yes, please provide the police report.

DECLARATION, AUTHORIZATION AND DATA PRIVACY CONSENT

I hereby declare that to the best of my knowledge and belief, the particulars and information as declared by me are true and complete in every respect and are made without reservation of any kind.

I understand, and if I am submitting this form on behalf of another individual, I have ensured that the individual understands, that if I/he/she make any false or fraudulent statements, or withhold material facts whatsoever, the policy may be void and I/he/she shall forfeit any or all rights to recover therein.

With respect to personal information collected pursuant to this claims submission, I agree and consent, and if I am submitting or releasing personal information relating to another individual, I represent and warrant that (A) I have the authority on behalf of that individual to provide or release that information and consent to the BHSIC Recipients; (B) I have informed the individual about the purposes for which his/her personal information is collected, used and disclosed as well as the parties to whom such personal information may be disclosed by the BHSIC Recipients, as set out below; and (C) the individual agrees and consents that the BHSIC Recipients may collect, use and process my/his/her personal information pursuant to this Data Privacy Consent.

I, on behalf of myself or that individual, authorise any hospital doctor or other person who has attended or examined me/him/her, to furnish to Berkshire Hathaway Specialty Insurance Company (BHSIC) and other BHSIC related bodies corporate, affiliates and branches, BHSIC's authorised representatives, service providers, professional advisors and business partners (BHSIC Recipients), any and all information relating to any illness or injury, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A copy of this authorisation shall be considered as effective and valid as the original.

(a) The personal information collected pursuant to any claims submission (or otherwise provided during the course of the claim process, including by way of call recordings) may be collected, used and disclosed by BHSIC to:

(i) administer and process the insurance claim;

(ii) investigate, assess, adjust and make a decision the claim;

(iii) administer my/his/her insurance policy (including pursuing recovery from reinsurers or other third parties)

(iv) handle disputes and complaints;

(v) respond to requests for information from public and governmental/regulatory authorities, statutory boards and for audit, compliance, investigation and inspection purposes;

(vi) respond to requests from the policyholder;

(vii) carry out due diligence or other screening activities (including background checks) in accordance with legal or regulatory obligations or risk management procedures that may be required by law or that may have been put in place by BHSIC;

(viii) comply with legal or regulatory obligations, risk management procedures and BHSIC internal policies, and

(ix) for other purposes stated in BHSIC's Privacy Policy Statement.

(b) BHSIC may transfer the personal information to the following (whether located in Singapore, Hong Kong, Macau or elsewhere) for the purposes identified in (a) above:

(i) third parties providing relevant services pertaining to the administration of my/his/her policy (including reinsurers) and processing of my/his/her claim;

(ii) BHSIC's agents;

(iii) brokers, my/his/her authorized agents or representatives or next-of-kin;

(iv) the policyholder;

(v) legal process participants and their advisors;

(vi) governmental/regulatory authorities, industry associations, courts, other alternative dispute resolution forums;

(vii) any financial institutions for the purpose of administering my/his/her claim and obtaining policy payments;

(viii) loss adjustors, assessors, third party administrators, emergency providers, legal services providers, retailers, medical providers and travel carriers, internal and external auditors;

(ix) any member of BHSIC group (for all the purposes stated in (a) above) in any country; or

(x) other parties referred to in BHSIC's Privacy Policy Statement.

Note:

The full version of BHSIC's Privacy Policy Statement can be found at https://www.bhspecialty.com/privacy-policy/privacy-policy-macau/.

Signature of Policyholder	Date (DD/MM/YY)
Name and Designation of Signatory	Company's/Policyholder's Name and Stamp
Telephone No.	E-mail Address

PART 2

(To be completed by the Insured Person)

Policy Number:

A. INSURED PERSON DETAILS

Name of Insured Person: _____ Sex: ☐ Male ☐ Female

Date of Birth: _____ (DD/MM/YYYY) Marital Status: _____

Macau ID /Passport No.: _____ Nationality: _____

Country of Residence: _____ Country of Assignment: _____

Home Address: _____

Email: _____ Contact Number: _____

B. DISABILITY STATUS

If you are making a claim for Disablement Benefit and/or Weekly Benefit, please provide the following details.

1. Describe the disability for which the claim is being made:

2. If the disability is caused by a bodily injury, was the injury caused by an accident? ☐ Yes ☐ No

If yes, please provide the following details:

Date of accident: _____ (DD/MM/YYYY) Country in which the accident occurred: _____

Location of accident: _____

Circumstances of accident:

Nature of bodily injury:

3. When did the bodily injury first manifest itself? Date: _____ (DD/MM/YYYY)

4. If a sickness has resulted in your disability, when and where was your health first affected by the sickness?

Date: _____ (DD/MM/YYYY) Country: _____ Location: _____

Description of Sickness: _____

5. Have you previously suffered the bodily injury or sickness giving rise to the claim? ☐ Yes ☐ No

If yes, please provide further details:

6. Are you currently seeing a doctor in connection with the disability for which a claim is being made? ☐ Yes ☐ No

If yes, please provide the relevant details below:

Name of Hospital/Clinic and address	Name of Doctor(s)	Date of Treatment (DD/MM/YYYY)	Type of Treatment

7. State briefly your occupation or profession and daily activities prior to the accident or sickness:

8. Are you prevented from performing your usual occupation? ☐ Yes ☐ No

If yes, is this expected to be temporary or permanent? ☐ Temporary ☐ Permanent

If temporary, the date on which you expect to return to work: _____
(DD/MM/YYYY)

9. Despite the disability are currently engaged in any other employment, either on a full time or part time basis? ☐ Yes ☐ No

If yes, please provide the following details:

Nature of employment: _____

Brief description of duties:

Date employment commenced: _____ ☐ Part time ☐ Full time
(DD/MM/YYYY)

Salary per month: _____

10. Are you receiving benefit from other source? *If yes, please furnish* ☐ Yes ☐ No

Source: _____ Amount: _____

11. Are you now receiving any income or claiming under any policy? ☐ Yes ☐ No

If Yes, please furnish the following:

Amount Per Month: _____ Name of Payor: _____

C. PLEASE USE THIS SECTION TO PROVIDE FURTHER INFORMATION IF NEEDED

PAYMENT DETAILS

Electronic Funds Transfer

Please provide details for the payment of this claim in the event that this claim is deemed payable by Berkshire Hathaway Specialty Insurance (BHSI). In such an event this claim shall be payable to the relevant insured person only in accordance to terms and conditions of the relevant policy.

Payee Name (name as per bank account): _____

Name of Bank: _____

Bank Address: _____

Swift Code: _____ IBAN: _____

Bank Code: _____ Branch Code: _____

Account Number: _____

Notification of payment will be sent to the email address stated in the "Insured Person Details" section of this form. If you require notification of payment to be sent to another address please provide details below:

Email: _____

Please note that all payments will be made directly to the Policyholder unless otherwise agreed. All payments will be made in the currency of the policy.

Important Notice:

BHSI 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 BHSI with an inaccurate bank account number under this section for the payment of this claim.

DECLARATION, AUTHORIZATION AND DATA PRIVACY CONSENT

I hereby declare that to the best of my knowledge and belief, the particulars and information as declared by me are true and complete in every respect and are made without reservation of any kind.

I understand, and if I am submitting this form on behalf of another individual, I have ensured that the individual understands, that if I/he/she make any false or fraudulent statements, or withhold material facts whatsoever, the policy may be void and I/he/she shall forfeit any or all rights to recover therein.

With respect to personal information collected pursuant to this claims submission, I agree and consent, and if I am submitting or releasing personal information relating to another individual, I represent and warrant that (A) I have the authority on behalf of that individual to provide or release that information and consent to the BHSIC Recipients; (B) I have informed the individual about the purposes for which his/her personal information is collected, used and disclosed as well as the parties to whom such personal information may be disclosed by the BHSIC Recipients, as set out below; and (C) the individual agrees and consents that the BHSIC Recipients may collect, use and process my/his/her personal information pursuant to this Data Privacy Consent.

I, on behalf of myself or that individual, authorise any hospital doctor or other person who has attended or examined me/him/her, to furnish to Berkshire Hathaway Specialty Insurance Company (BHSIC) and other BHSIC related bodies corporate, affiliates and branches, BHSIC's authorised representatives, service providers, professional advisors and business partners (BHSIC Recipients), any and all information relating to any illness or injury, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A copy of this authorisation shall be considered as effective and valid as the original.

(a) The personal information collected pursuant to any claims submission (or otherwise provided during the course of the claim process, including by way of call recordings) may be collected, used and disclosed by BHSIC to:
- (i) administer and process the insurance claim;
- (ii) investigate, assess, adjust and make a decision the claim;
- (iii) administer my/his/her insurance policy (including pursuing recovery from reinsurers or other third parties)
- (iv) handle disputes and complaints;
- (v) respond to requests for information from public and governmental/regulatory authorities, statutory boards and for audit, compliance, investigation and inspection purposes;
- (vi) respond to requests from the policyholder;
- (vii) carry out due diligence or other screening activities (including background checks) in accordance with legal or regulatory obligations or risk management procedures that may be required by law or that may have been put in place by BHSIC;
- (viii) comply with legal or regulatory obligations, risk management procedures and BHSIC internal policies, and
- (ix) for other purposes stated in BHSIC's Privacy Policy Statement.

(b) BHSIC may transfer the personal information to the following (whether located in Singapore, Hong Kong, Macau or elsewhere) for the purposes identified in (a) above:
- (i) third parties providing relevant services pertaining to the administration of my/his/her policy (including reinsurers) and processing of my/his/her claim;
- (ii) BHSIC's agents;
- (iii) brokers, my/his/her authorized agents or representatives or next-of-kin;
- (iv) the policyholder;
- (v) legal process participants and their advisors;
- (vi) governmental/regulatory authorities, industry associations, courts, other alternative dispute resolution forums;
- (vii) any financial institutions for the purpose of administering my/his/her claim and obtaining policy payments;
- (viii) loss adjustors, assessors, third party administrators, emergency providers, legal services providers, retailers, medical providers and travel carriers, internal and external auditors;
- (ix) any member of BHSIC group (for all the purposes stated in (a) above) in any country; or
- (x) other parties referred to in BHSIC's Privacy Policy Statement.

Note:

The full version of BHSIC's Privacy Policy Statement can be found at https://www.bhspecialty.com/privacy-policy/privacy-policy-macau/.

Signature of Insured Person

Policyholder's/Company's Name

Date (DD/MM/YY)

PART 3

(TO BE COMPLETED BY ATTENDING DOCTOR)

A. PATIENT'S PERSONAL DETAILS

Name of Insured Person (as in Macau ID): _____

Macau ID /Passport No.:_____ Date of Birth: _____ (DD/MM/YYYY)

Height: _____m Weight:_____kg Sex: ☐ Male ☐ Female

Home Address:_____

Email: _____ Contact Number: _____

B. MEDICAL INFORMATION

1. Are you the Insured Person's regular doctor? ☐ Yes ☐ No

If No, please advise name/address of the insured's regular medical attendant.

Name of Hospital/Clinic and address	Name of Doctor(s)

2. Describe the bodily injury or sickness afflicting the Insured Person:

3. If the Insured Person is suffering from a bodily injury, was this the result of an accident? ☐ Yes ☐ No

If yes, please provide the following details:

Date of the accident: _____ (DD/MM/YYYY) Location of accident:_____

Is the accident work related? ☐ Yes ☐ No

Brief description of the accident:

4. Is the bodily injury or sickness giving rise to a disability for which the claim is being made sports related? *If yes, please provide further details.* ☐ Yes ☐ No

5. Has the Insured Person previously suffered from the bodily injury or sickness giving rise to the claim? *If yes, please provide further details:* ☐ Yes ☐ No

6. When did the sickness or bodily injury complained of first manifest itself to the Insured Person?

   Date: _____
   (DD/MM/YYYY)

7. When did you first attend to the Insured Person for the bodily injury or sickness giving rise to a disability for which the claim is being made? Date: _____
   (DD/MM/YYYY)

8. Is there anything in the Insured Person's past medical history or way of life which may have caused or contributed to, or exacerbated the sickness or bodily injury that forms the subject matter of the claim? ☐ Yes ☐ No
   If yes, please provide further details:

9. Is the Insured Person currently receiving any treatment? ☐ Yes ☐ No
   If Yes, please furnish:

Name of Hospital/Clinic and address	Name of Doctor(s)	Date of Treatment (DD/MM/YYYY)	Type of Treatment

10. When was the Insured Person first given leave of absence from work? Date: _____
    (DD/MM/YYYY)

    If the leave of absence is continuing, please advise the expiry date of the current medical certificate:
    Date: _____
    (DD/MM/YYYY)

11. Is the Insured Person suffering total or partial disablement? ☐ Total ☐ Partial

    (Note: Total disablement means that the Insured Person is unable to engage in <u>any</u> part of their usual occupation. Partial disablement means that the Insured Person is unable to engage in a substantial part of their usual occupation.)

12. Is the disablement permanent or temporary? ☐ Permanent ☐ Temporary

    (Note: Permanent means that the disability will continue for twelve (12) consecutive months and there is no hope of improvement at the expiry of that time.)

13. If you view the disability which forms the subject matter of the claim as permanent and total, does the disability also prevent the Insured Person from engaging in any business, profession, occupation or employment? ☐ Yes ☐ No
    If no, please advise the nature of the business, profession, occupation or employment the Insured Person would be able to engage in notwithstanding the disability?

14. If you view the disability which forms the subject matter of the claim as temporary and partial, what duties do you believe the Insured Person would be fit to perform notwithstanding the disability?

How many hours per week would the Insured Person be able to work notwithstanding the disability?_____

15. Are there any other circumstances, medical or otherwise which may delay the Insured Person's recovery?

16. What has been the treatment plan for the Insured Person and what is the current treatment plan?
Please include details of medication, surgery, rehabilitation and frequency of visits.

When was the Insured Person's last consultation? Date: _____
(DD/MM/YYYY)

I_____ the undersigned, do hereby declare that I was the doctor in attendance during the sickness/injury giving rise to the disability for which a claim is now being made and that the foregoing answers are true to the best of my knowledge and belief and that no material fact has been concealed from Berkshire Hathaway Specialty Insurance Company.

_____	_____
Name of Doctor	Signature
_____	_____
Name of Clinic/Hospital	Professional Qualification
_____	_____
Postal Address	Date (DD/MM/YYYY)
_____	
Clinic/Hospital Stamp	

PART 4

(To be completed by the Insured Person)

A. INSURED PERSON DETAILS

Name of Insured Person: _____ Sex: ☐ Male ☐ Female

Date of Birth: _____ Marital Status: _____

Macau ID /Passport No.:_____ Nationality:_____

Country of Residence:_____ Country of Assignment:_____

Address:_____

Email: _____ Contact Number: _____

B. TRAVEL INFORMATION (*If Applicable*)

Date of Departure: _____ (DD/MM/YYYY) Date of Return/Expected Return: _____ (DD/MM/YYYY)

Reason for Travel: ☐ Business ☐ Business & Leisure ☐ Leisure ☐ Other

If other, please specify: _____

Departure Country: _____ Departure City: _____

Destination Country: _____ Destination City: _____

C. OVERSEAS MEDICAL EXPENSES CLAIM

Injury/Illness/Sickness or Disease Information

(Please provide itemized bills and invoices and medical reports (if applicable) for all medical expenses claimed)

Describe the injury/illness/sickness or disease:

Country in which medical expenses were incurred:

Claim Information

Date Expense Incurred (DD/MM/YYYY)	Clinic	Details of all Medical Treatment	Amount
		Total Amount Claimed	

Is your treatment continuing? ☐ Yes ☐ No

If yes, please provide further details:

If you are a U.S. citizen, have you submitted any medical bills to U.S. Medicare? ☐ Yes ☐ No

If yes, please provide:

Social Security Number: _____

Details of the bills concerned:

D. BAGGAGE & PERSONAL EFFECTS CLAIM

Was your baggage delayed? ☐ Yes ☐ No

If yes, please provide the following details:

Date of arrival at destination: _____ (DD/MM/YYYY) Time of arrival at destination: _____

Date on which baggage was received: _____ (DD/MM/YYYY) Time at which the baggage was received: _____

Have you received compensation from your transport operator? ☐ Yes ☐ No

If yes, please provide evidence of the compensation received.

Was your baggage or were your personal effects lost or damaged? ☐ Yes ☐ No

If yes please provide a brief summary of the circumstances leading to the loss of/damage to baggage or personal effects:

Date on which the loss/damage occurred: _____ (DD/MM/YYYY)

Location (including city and country) where the loss/damage occurred: _____

Were the police informed? ☐ Yes ☐ No

If yes, please provide the police report or number: _____

Please attach a copy of the report.

Have you submitted a claim for compensation for lost baggage or personal effects from your transport provider? ☐ Yes

Please attach a copy of any report or correspondence provided by the transport provider.

If you have not submitted a claim for compensation from your transport provider you will need to do this before submitting a claim to us.

Claim Details

Item	Date Purchased (DD/MM/YYYY)	Personal Effect?	Business/Company Owned?	Replacement Amount
Less amount paid in compensation by either the transport provider or any other insurance				
Total Amount Claimed				

E. CANCELLATION AND DISRUPTION CLAIM

Type of claim:

☐ Loss of Deposits ☐ Cancellation & Disruption ☐ Financial Insolvency ☐ Missed Transport Connection

☐ Overbooked Flights ☐ Travel Delay

Cause of claim:

☐ Insured Person's unexpected bodily injury, sickness or death

☐ Unexpected serious sickness or serious injury or death of an Insured Person's relative, colleague or travelling companion

☐ Unforeseen circumstances outside of the control of you or the Insured Person
Please use this section to describe the unforeseen circumstances:

☐ Refusal, failure or inability of any person, company or organisation to provide services, facilities or accommodation by reason of financial default or insolvency

☐ Missed travel connection due to unforeseeable circumstances outside your or the Insured Person's control

☐ Denied boarding because of overbooked flights

☐ Industrial action by the employees of the transport operator

☐ Mechanical fault of the conveyance intended to be used

☐ Bad weather

☐ Other reasonable cause beyond the control of the transport operator
Please use this section to provide further details:

Details of the changed itinerary (if applicable):

Date intended to travel (DD/MM/YYYY)	Dates actually travelled (DD/MM/YYYY)

Cities intended to travel to	Cities actually travelled to

Lost Travel and Accommodation Expenses

Airfares/Airline	Accommodation	Currency	Amount Paid	Amount Refunded	Amendment Cost	Cancellation Cost
Subtotal Amount Claimed						
Total Amount Claimed						

Additional Expenses Incurred

Expense Detail	Date Expense Incurred (DD/MM/YYYY)	Amount
Less any compensation received from airline, hotel etc.		
Total Amount Claimed		

F. PERSONAL LIABILITY

1. Date incident happened: _____ (DD/MM/YYYY) 2. Time of incident: _____
3. Country and Location of incident: _____
4. Did the incident result in: ☐ Third Party bodily injury ☐ Third Party property damage ☐ Both
5. Description of the circumstances leading up to the incident together with details of any bodily injury or property damage suffered by the third party:

6. Has a claim been made against you by a third party? ☐ Yes ☐ No
   If yes, please provide details.

7. Details of the third party(s) involved:

   Name: _____ Name: _____

   Address: _____ Address: _____

   Post Code: _____ Post Code: _____

   Contact Number: _____ Contact Number: _____

   Contact email: _____ Contact email: _____

8. Details of any witnesses to the incident :

Name: _____ Name: _____

Address: _____ Address: _____

Post Code: _____ Post Code: _____

Contact Number: _____ Contact Number: _____

Contact email: _____ Contact email: _____

9. Details of any other insurance held by the Insured Person covering personal liability:

Name and address of the insurance company: _____

Policy number: _____ Will a claim be made on this insurance policy? ☐ Yes ☐ No

G. PLEASE USE THIS SECTION TO PROVIDE FURTHER INFORMATION IF NEEDED

PAYMENT DETAILS

Electronic Funds Transfer

Please provide details for the payment of this claim in the event that this claim is deemed payable by Berkshire Hathaway Specialty Insurance (BHSI). In such an event this claim shall be payable to the relevant insured person only in accordance to terms and conditions of the relevant policy.

Payee Name (name as per bank account): _____

Name of Bank: _____

Bank Address: _____

Swift Code: _____ IBAN: _____

Bank Code: _____ Branch Code: _____

Account Number: _____

Notification of payment will be sent to the email address stated in the "Your Information" section of this form. If you require notification of payment to be sent to another address please provide details below:

Email: _____

Please note that all payments will be made directly to the Policyholder unless otherwise agreed. All payments will be made in the currency of the policy.

Important Notice:

BHSI 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 BHSI with an inaccurate bank account number under this section for the payment of this claim.

DECLARATION, AUTHORIZATION AND DATA PRIVACY CONSENT

I hereby declare that to the best of my knowledge and belief, the particulars and information as declared by me are true and complete in every respect and are made without reservation of any kind.

I understand, and if I am submitting this form on behalf of another individual, I have ensured that the individual understands, that if I/he/she make any false or fraudulent statements, or withhold material facts whatsoever, the policy may be void and I/he/she shall forfeit any or all rights to recover therein.

With respect to personal information collected pursuant to this claims submission, I agree and consent, and if I am submitting or releasing personal information relating to another individual, I represent and warrant that (A) I have the authority on behalf of that individual to provide or release that information and consent to the BHSIC Recipients; (B) I have informed the individual about the purposes for which his/her personal information is collected, used and disclosed as well as the parties to whom such personal information may be disclosed by the BHSIC Recipients, as set out below; and (C) the individual agrees and consents that the BHSIC Recipients may collect, use and process my/his/her personal information pursuant to this Data Privacy Consent.

I, on behalf of myself or that individual, authorise any hospital doctor or other person who has attended or examined me/him/her, to furnish to Berkshire Hathaway Specialty Insurance Company (BHSIC) and other BHSIC related bodies corporate, affiliates and branches, BHSIC's authorised representatives, service providers, professional advisors and business partners (BHSIC Recipients), any and all information relating to any illness or injury, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A copy of this authorisation shall be considered as effective and valid as the original.

(a) The personal information collected pursuant to any claims submission (or otherwise provided during the course of the claim process, including by way of call recordings) may be collected, used and disclosed by BHSIC to:
   (i) administer and process the insurance claim;
   (ii) investigate, assess, adjust and make a decision the claim;
   (iii) administer my/his/her insurance policy (including pursuing recovery from reinsurers or other third parties)

(iv) handle disputes and complaints;

(v) respond to requests for information from public and governmental/regulatory authorities, statutory boards and for audit, compliance, investigation and inspection purposes;

(vi) respond to requests from the policyholder;

(vii) carry out due diligence or other screening activities (including background checks) in accordance with legal or regulatory obligations or risk management procedures that may be required by law or that may have been put in place by BHSIC;

(viii) comply with legal or regulatory obligations, risk management procedures and BHSIC internal policies, and

(ix) for other purposes stated in BHSIC's Privacy Policy Statement.

(b) BHSIC may transfer the personal information to the following (whether located in Singapore, Hong Kong, Macau or elsewhere) for the purposes identified in (a) above:

(i) third parties providing relevant services pertaining to the administration of my/his/her policy (including reinsurers) and processing of my/his/her claim;

(ii) BHSIC's agents;

(iii) brokers, my/his/her authorized agents or representatives or next-of-kin;

(iv) the policyholder;

(v) legal process participants and their advisors;

(vi) governmental/regulatory authorities, industry associations, courts, other alternative dispute resolution forums;

(vii) any financial institutions for the purpose of administering my/his/her claim and obtaining policy payments;

(viii) loss adjustors, assessors, third party administrators, emergency providers, legal services providers, retailers, medical providers and travel carriers, internal and external auditors;

(ix) any member of BHSIC group (for all the purposes stated in (a) above) in any country; or

(x) other parties referred to in BHSIC's Privacy Policy Statement.

Note:

The full version of BHSIC's Privacy Policy Statement can be found at https://www.bhspecialty.com/privacy-policy/privacy-policy-macau/.

Signature of Insured Person	Policyholder's/Company's Name
Date (DD/MM/YY)	