Berkshire Hathaway Specialty Insurance

Accident & Health

GROUP PERSONAL ACCIDENT CLAIM FORM

INSTRUCTIONS:

Please complete all relevant sections of the claim form.

1. Part 1 of the claim form needs to be completed by the Policyholder;
2. Part 2 of the claim form needs to be completed by the Insured Person making the claim;
3. Completed Parts 1 and Part 2 must be submitted to BHSI within thirty (30) days of the sickness or accident for which a claim is being made.
4. Part 3 of the claim form needs to be completed by the attending doctor and submitted to BHSI.

Note: *In the event of the Accidental Death of the Insured Person, only Part 1 of the claim form needs to be submitted to BHSI with supporting documentation. On receipt of the claim, BHSI will provide further guidance and assistance as to the next steps to be taken.*

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 6262 1608.

PART 1

(To be completed by the Policyholder)

Policy Number:

A. POLICYHOLDER/INSURED PERSON DETAILS

Name of Policyholder: _____

Name of Insured Person: _____

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

Nationality: _____ Sex: ☐ Male ☐ Female

Occupation: _____

Effective Date of Employment:_____ Effective Date of Insurance: _____
(DD/MM/YYYY) (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 Part 2 and have their doctor complete Part 3.

C. DISABILITY STATUS OF THE INSURED PERSON

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

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

3. When did the Insured Person suffer the sickness/bodily injury? _____
(DD/MM/YYYY)

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

5. 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)

6. 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 work injury compensation insurer? ☐ Yes ☐ No

If yes, please provide:

(i) the name and address of your work injury 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 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: _____

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

Nationality: _____ Sex: ☐ Male ☐ Female

Home Address:_____ Marital Status: _____

Email: _____ Contact Number: _____

B. SURGERY OUTSIDE OF MACAU

If you have undergone surgery outside of Macau as a result of sickness or bodily injury, please provide the following details.

1. Was the surgery the result of bodily injury or sickness? ☐ bodily injury ☐ sickness
2. If bodily injury, did this result from an accident? ☐ Yes ☐ No
   If yes, please provide the following:

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

   Brief description of the accident:

3. If sickness, on what date did you first become aware of the sickness? Date: _____ (DD/MM/YYYY)
4. Name and address of hospital where surgery was performed:

   Contact details of doctor performing the surgery:

   Name: _____ Phone Number:_____

   Email: _____

5. Description of surgery conducted:

C. 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) Location of accident: _____ (DD/MM/YYYY)

Circumstances of accident:

Nature of bodily injury:

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

4. If sickness has resulted in your disability, please give full details of the sickness:

When was your health first affected by the sickness? Date: _____ (DD/MM/YYYY)

5. Have you previously suffered the same bodily injury or sickness? ☐ 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 you 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 benefits from any other source? ☐ Yes ☐ No

If yes, please furnish the following:

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: _____

D. OTHERS

If you wish to make a claim for a benefit not covered by Sections B and C above, please provide the following details.

Description of loss/event:

Description bodily injury:

Date expenses incurred (DD/MM/YYYY)	Type of expenses	Treatment Received	Services provided by	Claimed Amount

E. 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)	

PART 3 – MEDICAL REPORT (INPATIENT CLAIMS)

(TO BE COMPLETED BY ATTENDING DOCTOR)

A. PATIENT'S PERSONAL DETAILS

Name of Insured Person (as in NRIC): _____

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

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

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. Is this condition a bodily injury ☐ or sickness ☐

Diagnosis: (if fracture or dislocation, please describe nature and location ie Simple, Compound)

Cause:

3. If this is 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:_____

Brief description of the accident:

4. Is the accident work related? ☐ Yes ☐ No

Is the bodily injury or sickness 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?

Date: _____
(DD/MM/YYYY)

8. Did the injury or sickness require hospitalisation? ☐ Yes ☐ No

If yes, please provide period of hospitalization: From _____ (DD/MM/YYYY) to _____ (DD/MM/YYYY)

If yes, please provide a copy of the Hospital Discharge Summary Report/Medical Report.

9. Did the Insured Person undergo surgery? ☐ Yes ☐ No

If yes, please provide details of surgery:

(a) Description of surgery performed:

(b) Date of surgery: _____
(DD/MM/YYYY)

(c) Name and address of hospital where surgery was performed:

10. 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

11. When was the Insured Person first certified unfit to work? Date: _____
(DD/MM/YYYY)

If the leave of absence is continuing, please provide dates of medical leave:

From _____ (DD/MM/YYYY) to _____ (DD/MM/YYYY)

12. 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.)

13. 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.)

14. 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

15. If no, does the condition prevent the Insured Person from engaging in their usual profession, occupation or employment? ☐ Yes ☐ No
If no, what duties do you believe the Insured Person would be fit to perform notwithstanding the disability?

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

16. 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:

a) Does the Insured Person suffer from any pre-existing medical conditions which may have contributed to the sickness or bodily injury? ☐ Yes ☐ No
If yes, please provide further details:

b) Are there any circumstances, such as the influence of alcohol, drug or any other intoxication substance or physical defect which may have contributed to the sickness or bodily injuries and/or lengthen the period of disability? ☐ Yes ☐ No
If yes, please provide further details:

c) Are there any other circumstances, medical or otherwise which may delay the Insured Person's recovery? ☐ Yes ☐ No
If yes, please provide further details:

17. 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	