AIA International Limited
(Incorporated in Bermuda
with limited liability)

GROUP MEDICAL INSURANCE – HOSPITALIZATION & SURGICAL CLAIM FORM
團體醫療保險－住院及手術賠償申請表

(This form is applicable to both inpatient and outpatient surgical claim)
（本申請表格適用於住院及門診手術賠償）

PART I – Member Information – TO BE COMPLETED BY THE MEMBER / INSURED EMPLOYEE
甲部－成員資料（由成員／受保僱員填寫）

***** Please complete all the information below, otherwise, it cannot be processed. ***** 請填妥以下資料，否則閣下之賠償申請將不能處理
** Please provide contact information. It will be updated to our record in accordance with the arrangement with your employer. **請提供聯絡資料，我們將根據與您的僱主所訂下的安排更新該等資料

1. Group Policy No. 團體保單編號 :*	7. Name of Employer / Group Policyholder 僱主／團體保單投保公司名稱 :*
2. Name of Insured Employee / Member 受保僱員／成員姓名 : *	8. HK/Macau ID No. of the Insured Employee 受保僱員香港/澳門身份証 : *
3. Mobile number of Insured Employee 受保僱員手提電話 : **	9. Claimant Member ID (10 digits no. shown in the medical card) (**Compulsory**) 賠償申請人成員號碼(醫療卡上顯示的十位數字)(**必須填寫**): *
4. E-mail Address of Insured Employee 受保僱員電郵地址 : **	***Please complete items 10 to 11 if item 9 cannot be provided ***如未能提供第九項之資料，請填妥第十至十一項
5. Name of Claimant / Patient 賠償申請人／病者姓名 : *	10. Certificate No. of the Insured Employee 受保證書號碼 : ***
6. Relationship to Insured Employee / Member 與受保僱員／成員之關係 : * ☐ Self 本人 ☐ Spouse 配偶 ☐ Children 子女 ☐ Others 其他: _____	11. Employee No. of the Insured Employee 僱員編號 : ***

12. Have you / the claimant had any prior treatment for this or related conditions? 閣下／賠償申請人是否曾經因同一病況而接受治療？

☐ No 沒有 ☐ Yes 有 Doctor's Name 醫生姓名: _____ Date(s)日期: _____

Address 地址: _____

13. Are you / the claimant making any other insurance claim as a result of this hospitalization / surgery? 有關此次住院／手術，閣下／賠償申請人有否申請其他保險賠償？

☐ No 沒有 ☐ Yes 有 Name of Insurance Company 保險公司名稱 : _____

Policy No. 保單編號 : _____ Type of Compensation 賠償類別 : _____

14. Will you / the claimant also apply for insurance claim under any individual policy(ies) with AIA (where applicable) by this claim if the medical expenses exceed the coverage amount of the Group Policy? 如是次的醫療開支超出團體保單的保障額， 閣下/ 賠償申請人會否同時經此賠償申請向友邦保險的個人保單(如適用)申請保險賠償?

☐ No 不會 ☐ Yes 會 If yes, please specify the Policy No. 如會，請註明保單編號: _____ Agent Code 營業員號碼: _____

If no agent code is specified above, AIA would notify this claim's information to your AIA financial planner / broker / IFA according to the Company's record. If you do not want AIA to inform them of this application, please tick the box ☐. 就是次賠償，若營業員資料一欄中沒有指定跟進之營業員資料，我們將根據友邦之記錄，通知您的友邦財務策劃顧問 / 保險顧問 / 投資顧問。如閣下不欲友邦就是次申請通知上述顧問，請在方格內劃上剔號 ☐。

15. Was the hospitalization / surgery a result of an accident? 此次住院／手術是否由於一宗意外引致？

☐ No 不是 ☐ Yes 是 Date 日期 : _____ Time 時間 : _____ Place 地點 : _____

Brief Description 經過: _____

Note for filing a claim

1. Part I should be completed by the Insured Employee / Member while Part II by Attending Physician.
2. Original bills and receipts for the claimed expenses must be attached showing the date of treatment, patient's name, diagnosis and the Attending Physician's stamp and signature.
3. Referral letter must be attached for specialist consultation.
4. Claim for hospitalization & surgical expenses are advised to be submitted **WITHIN 90 days** from the date of leaving the hospital / surgery to facilitate earlier claim settlement. (Please note that any claims submitted after 90 days will be denied.)
5. Please make copies as necessary. Certified true copies of bills and / or receipts will be provided if specified in this form.
6. How to submit the claim form?
   - Fill in the claim form and sign
   - Attach the original claim receipt
   - Send to your Human Resources Department or plan administrator (if applicable)
7. You may logon AIA Employee Benefits Online Service through AIA.COM.HK to check your processed claim records.
8. AIA address in HK : AIA International Limited, AIA Corporate Solutions, 12/F, AIA Financial Centre, 712 Prince Edward Road East, Kowloon, Hong Kong
   AIA address in Macau : AIA International Limited, AIA Corporate Solutions, 1903, AIA Tower, Nos. 251A-301 Avenida Commercial de Macau, Macau

申請賠償須知

1. 此表格之甲部由受保僱員／成員填寫，而乙部則須由主診醫生填報。
2. 必須附上正本單據及收條，單據及收條須包括診症日期、病者姓名、診斷以及主診醫生蓋章及簽署。
3. 專科賠償，必須附上轉介推薦書。
4. 為使早日完成賠償，住院／手術費用賠償申請，請於出院後／手術日起**九十日內**遞交。(請注意：友邦保險不受理診斷日期／出院九十日後才提出的賠償申請。)
5. 請自行影印副本。如清楚註明於本申請表，友邦保險將會提供單據及/或收條之核證副本。
6. 如何遞交賠償申請表?
   - 填寫此申請表及簽署
   - 請附上理賠收據正本
   - 交回貴公司人事部或有關負責人(如適用)
7. 您可隨時登入 AIA.COM.HK 之友邦僱員福利網上服務查閱閣下已被處理的理賠紀錄。
8. 友邦香港辦事處:香港九龍太子道東 712 號友邦九龍金融中心 12 樓友邦企業業務
   澳門友邦保險辦事處:澳門商業大馬路 251A-301 號友邦廣場 1903 室友邦企業業務

Logon 24-hour AIA Employee Benefits Online Service through AIA.COM.HK to check your claim records and / or benefit now!
請登入 AIA.COM.HK 之 24 小時友邦僱員福利網上服務查閱您的賠償紀錄及 / 或福利概要

Declaration and Authorization

I / We hereby irrevocably authorize:

(i) any organization, institution or individual that has any record or knowledge of my / the insured(s)'s employment, sick leave records, accident or loss details (of any sorts), health and medical history or any treatment or advice that has been or may hereafter be consulted to disclose to AIA such information. This authorization shall bind my / the insured(s)'s successors and assignees and remain valid notwithstanding my / the insured(s)'s death or incapacity in so far as legally possible. A photocopy of the authorization shall be as valid as the original.

(ii) AIA or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests, to underwrite and evaluate my / the insured(s)'s health status in relation to this application and any claim arising therefrom. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, acquired immue deficiency syndrome (AIDS), infection by any human immunodeficiency virus (HIV), immune disorder or the presence of medications, drugs, nicotine or their metabolites.

I / We hereby agree with and authorize AIA to deduct the reimbursement of claims payment in the event that I, and / or my dependents, have any shortfall amount, for whatever reason, due to AIA.

DIRECT PROMOTIONAL AND MARKETING MATERIALS

I / We confirm that I / we have read and understood the AIA Personal Information Collection Statement ("AIA PIC"). I / We agree to the provision and use of my / our personal data for direct marketing purposes in accordance with the AIA PIC. I / We acknowledge and consent to the transfer of my / our personal data outside of Hong Kong (for policies issued in Hong Kong) or Macau (for policies issued in Macau) for direct marketing purposes and to the types of transferee as set out in the AIA PIC.

☐ **Please tick the box on the left if you do not agree with the provision, use and transfer of your personal data for direct marketing purposes in accordance with the AIA PIC.**

PERSONAL DATA COLLECTION AND USE

I / We confirm that I / we have read and understood the AIA Personal Information Collection Statement ("AIA PIC"). I / We declare and agree that any personal data and other information relating to me / us or my / our policy(ies) or investments contained in this claim form or collected, obtained, compiled or held by AIA by any means from time to time may be collected and utilized in accordance with the AIA PIC. I / We acknowledge and consent to the transfer of my / our personal data outside of Hong Kong (for policies issued in Hong Kong) or Macau (for policies issued in Macau), as the case may be, for the purposes and to the types of transferee as set out in the AIA PIC.
The updated version of AIA PIC is available for download from its website: www.aia.com.hk, and is made available upon request.

聲明及授權

本人／我們茲授權：

(i) 任何知悉或擁有本人／受保人之工作、病假記錄、意外或損失（任何類別）之詳情、健康狀況及病歷或任何治療或諮詢記錄及曾為或將為本人／受保人診治之機構、組織或人士，友邦保險透露有關資料，不得撤回。即使本人／受保人死亡或喪失能力，此授權書仍然存有法律效力，而本人／受保人之繼承人及轉讓人亦會受此授權書約束。此授權書之正本與副本同屬有效。

(ii) 友邦保險或任何其認可之驗身醫生或化驗所，替本人／受保人進行所需之醫療評估及測試，並對本人／受保人之健康狀況進行審核及評估，作為處理本申請及其後與之有關的賠償事宜，不得撤回。此等化驗會包括，但並不限於膽固醇及有關之血脂肪、糖尿病、肝或腎功能失常、愛滋病或感染人體免疫力缺乏病毒、免疫系統失常或體內藥物、毒品、尼古丁及其代謝物之含量等化驗。

本人／我們同意及授權友邦保險於賠償金額上扣除本人及／或本人家屬尚未清還友邦保險之任何欠款。

宣傳及市場推廣資料

本人／我們現確定本人／我們已閱讀及明白 AIA 個人資料收集聲明（「AIA 個人資料收集聲明」）。本人／我們同意根據 AIA 個人資料收集聲明，提供本人／我們的個人資料用作直銷推廣用途。
本人／我們確認及贊同把本人／我們的個人資料轉移至香港(如保單在香港繕發)或澳門(如保單在澳門繕發)境外作直銷推廣用途，並把相關的個人資料轉移至 AIA 個人資料收集聲明中列明的資料承讓人。

☐ **倘若不同意根據 AIA 個人資料收集聲明，提供、使用及轉移個人資料用作直銷推廣用途，請在上列☐一欄劃上✓。**

個人資料收集及使用

本人／我們確認本人／我們已閱讀及明白 AIA 個人資料收集聲明（「AIA 個人資料收集聲明」）。本人／我們聲明及同意在本申請所載或 AIA 不時以任何方法收集所得、編製或持有的任何個人資料及關於本人／我們或本人／我們的保單或投資的其他資料，可根據 AIA 個人資料收集聲明收集及使用。本人／我們知悉及同意就 AIA 個人資料收集聲明所述目的視乎情況轉讓本人／我們的個人資料至香港(如保單在香港繕發)或澳門(如保單在澳門繕發)境外予 AIA 個人資料收集聲明所載的資料承讓人。
AIA 個人資料收集聲明的最新版本可於 AIA 網址下載：www.aia.com.hk，及可向 AIA 索取。

Signature of Insured Employee / Member 受保僱員／成員簽署	Signature of Patient (18 years of age or over) 病者簽署（十八歲或以上）	Date Signed 簽署日期

Remarks : "AIA" refers to AIA International Limited (incorporated in Bermuda with limited liability)
備註 :「友邦保險」是指友邦保險(國際)有限公司(於百慕達註冊成立之有限公司)

PART II – TO BE COMPLETED BY THE SURGEON OR ATTENDING PHYSICIAN
乙部－必須由主診醫生填寫

Patient's Name:
病者姓名: _____

Patient's HK/Macau ID Card No.:
病者香港/澳門身份証編號: _____

1. a. What was the period of hospitalization? 住院期間
Admission Date 入院日期 Discharged Date 出院日期

_____ _____

_____ _____

_____ _____

2. a. Please give chief complaint / diagnosis for this hospitalization.
此次住院之病情 / 診斷

_____

b. Describe the type of treatment / surgical procedure given to the patient.
治療及手術詳情

_____

_____

3. When were the symptoms first presented or when did the accident happen?
首次出現病徵的日期或意外發生的日期

_____

4. a. When was the first consultation for this treatment / sickness?
首次就此病徵 / 狀況及有關病而就診的日期

_____

b. Has the patient received continuous treatment related to this sickness since then? 自首次受診後，病者有否繼續接受同類治療

_____

_____

5. If such hospitalization was due to accident, please state how it happened.
如是次入院由意外引起，請註明如何發生

_____

6. Was the patient referred to you by another doctor?病人是否經其他醫生轉介
☐ No 否 ☐ Yes 是

If "Yes", please give name and address of the referring doctor.
若是，請列轉介醫生的姓名及地址
Doctor's Name 醫生的姓名 Address 地址

_____

7. a. Have you treated the above patient for this or related sickness before?
在這之前，閣下有否就同樣疾病治療病者
☐ No 沒有 ☐ Yes 有, please give details 請詳述之

_____

_____

b. Was the condition a recurrent episode or a chronic disease?
此病況是否再次復發或是慢性疾病
☐ No 否 ☐ Yes 是, it was 此病乃 _____

8. Was the condition caused by or in any way associated with the conditions mentioned below? 病人之病情是否由下列情況所導致或有關連

Conditions 情況	Yes 是	No 否
a. the influence of drugs or alcohol intake? 藥物或酒精	☐	☐
b. AIDS, venereal disease or sexually transmitted disease? 愛滋病，性病或由性接觸而傳染的疾病	☐	☐
c. infertility or sterilization? 不育或節育	☐	☐
d. cosmetic or plastic surgery? 美容或整容手術	☐	☐
e. mental or nervous disorder? 精神錯亂	☐	☐
f. congenital deformities or anomalies? 先天性異常	☐	☐
g. suicide, insanity or self-infliction? 自殺，神智不清或自殘	☐	☐
h. correction of eye sight? 視力改正	☐	☐

9. a. Were the treatment(s), the medical test(s) and the length of stay in hospital (if any) directly related to the current diagnosis, and were medically necessary and recommended by you? 是次檢查、治療及住院日數(如有)是否和上述診斷有直接關係而且是醫療所需及由醫生建議?

☐ Yes 是 ☐No 否,
If No, please give details. 若不是，請詳述之 _____

Please answer the following questions if the insured requires hospitalization:
若受保人需要住院,請回答以下問題:

b. Were the medical test(s) and equipment for the procedure available only in hospital? 該檢查及手術所需的設備是否僅在醫院可有?

☐ Yes 是 ☐No 否

c. Can the medical test(s) and the procedure be done on an outpatient basis / at day surgery centre? 該檢查及手術可否在門診/日間手術中心進行?

☐ Can 可以 ☐ Cannot 不可以

d. The surgery could only be performed under general anaesthesia? 手術是否必須全身麻醉下進行?

☐ Yes 是 ☐No 否

For surgery under Monitored Anaesthesia Care, please specify the reason for hospital stay. 如手術在監察麻醉下進行，請註明住院原因.

_____

e. Please indicate the clinical risk(s) and medical reason(s) for hospitalization:
請註明臨床風險及須留院的醫療原因:

Current Health Status (Co-morbidity) 現時健康狀況(合併症):
Please Specify 請明確說明:

_____

Expected higher risk at operation 預期較高手術風險:
Please Specify 請明確說明:

_____

Expected higher post-operative risk 預期較高手術後風險:
Please Specify 請明確說明:

_____

Others, please specify the reason for admission and hospitalization:
其他，請註明必須入院及留院的原因:

_____

f. Is it a case of emergency? 這是否緊急個案?
☐ Yes 是 ☐No 否
If Yes, please specify. 如是,請明確說明. _____

10. Did any complications arise during such hospitalization?
是次住院有否引起併發症
☐ No 沒有 ☐ Yes 有, please give details 請詳述之_____

11. Did the patient take any home leave during the hospital confinement?
病人有否於住院期間離開醫院?

☐ No 沒有 ☐ Yes 有

If "Yes", please state the date and time.
若有，請詳述日期及時間

_____

_____ _____

Name of Attending Physician & Qualifications 主診醫生的姓名及專業資格 Signature and Stamp of Attending Physician 主診醫生之印鑑及簽名

_____ _____ _____

Address 地址 Telephone No. 電話號碼 Date 日期

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