



Submit your eClaim using the "AIA Connect" app:
Three simple steps: 1/ fill in basic information
2/ upload a photo of the receipt
3/ get your reimbursement in as little as 3 days

透過「友聯繫」應用程式遞交電子索償：

3個簡單步驟：1/ 輸入基本資料 2/ 上載賬單圖像 3/ 可於短至3天收到賠償



AIA International Limited
(Incorporated in Bermuda with limited liability)

GROUP INSURANCE MEDICAL CLAIM FORM
團體保險醫療賠償申請表

This form is to be completed in block letter by the Insured Employee / Member and separate forms must be used for different claimants (i.e. patients).
此申請表由受保僱員 / 成員以正楷填寫，每表祇限一位賠償申請人（即病者）使用。

* 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：*	6. 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：*	7. HK / Macau ID No. of the Insured Employee 受保僱員香港 / 澳門身份證：*										
3. Mobile number of Insured Employee 受保僱員手提電話：**	8. 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：**	<table border="1" style="width: 100%; height: 40px;"> <tr> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> </tr> </table>										
5. Name of Claimant / Patient 賠償申請人 / 病者姓名：*	9. Relationship to Insured Employee / Member 與受保僱員 / 成員之關係：* <input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Children 子女 <input type="checkbox"/> Others 其他：_____										

*** Please complete items 10 to 11 if item 8 cannot be provided. 如未能提供第八項之資料，請填妥第十至十一項。

10. Certificate No. of the Insured Employee 受保證書號碼：***	11. Employee No. of the Insured Employee 僱員編號：***
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12. Treatment Date 診治日期 (MM/DD/YY)	Presented Amount 收據金額	Type of claim (Please tick ✓ *) 賠償申請類別（請在適當方格內加✓號*）
_____	_____	<input type="checkbox"/> GP ¹ <input type="checkbox"/> SP ² <input type="checkbox"/> Dental ³ <input type="checkbox"/> Maternity ⁴ <input type="checkbox"/> Minor Op ⁵ <input type="checkbox"/> Pre / Post Hosp ⁶ <input type="checkbox"/> Others ⁷ _____
_____	_____	<input type="checkbox"/> GP ¹ <input type="checkbox"/> SP ² <input type="checkbox"/> Dental ³ <input type="checkbox"/> Maternity ⁴ <input type="checkbox"/> Minor Op ⁵ <input type="checkbox"/> Pre / Post Hosp ⁶ <input type="checkbox"/> Others ⁷ _____
_____	_____	<input type="checkbox"/> GP ¹ <input type="checkbox"/> SP ² <input type="checkbox"/> Dental ³ <input type="checkbox"/> Maternity ⁴ <input type="checkbox"/> Minor Op ⁵ <input type="checkbox"/> Pre / Post Hosp ⁶ <input type="checkbox"/> Others ⁷ _____
_____	_____	<input type="checkbox"/> GP ¹ <input type="checkbox"/> SP ² <input type="checkbox"/> Dental ³ <input type="checkbox"/> Maternity ⁴ <input type="checkbox"/> Minor Op ⁵ <input type="checkbox"/> Pre / Post Hosp ⁶ <input type="checkbox"/> Others ⁷ _____

13. 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，我們將根據友邦之紀錄，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。

Remarks 附註： 1.GP = Outpatient - General Physician's Consultation 門診普通科 2.SP = Outpatient - Specialist Physician's Consultation is included in the Outpatient Benefits and attach with referral letter(if applicable) 門診專科是門診福利下之專科醫療服務及需附上轉薦信（如適用） 3.Dental = 牙科治療 4.Maternity = Pre/Post Natal check is included in the Maternity Benefits (if applicable) 於懷孕前 / 生產後之門診檢查（如適用） 5.Minor Op = Minor Operation 於診所內進行之小手術 6.Pre/Post Hosp = Pre / Post-hospitalization consultation 住院前 / 後之診症 7.Others = Physiotherapy / X-ray / Lab tests / etc. 其他 = 物理治療 / X光 / 化驗 / 等

Log onto AIA Employee Benefits Online Service through AIA.COM.HK or AIA Connect mobile app to check your claim records and benefits now!
請登入AIA.COM.HK之友邦僱員福利網上服務或手機程式「友聯繫」查閱您的賠償紀錄及福利概要

INSTRUCTIONS

- (1) This form is to be completed in block letter by the Insured Employee / Member and separate forms must be used for different claimants (i.e. patients).
- (2) Claim for clinical / dental expenses must be submitted **WITHIN 90 days** from incurring such expenses. Otherwise, the claims will be declined for reimbursement.
- (3) Original bills or receipts for the claimed expenses must be attached showing the date of treatment, patient's name, diagnosis, itemized expenses, type of treatment and the attending physician / dental surgeon's stamp and signature.
- (4) Claim for expenses incurred in buying medicines / drugs and / or claim for undergoing X-ray examination / laboratory tests must be supported by the attending physician's prescription and / or recommendation and the original bills / receipts from the pharmacy and / or laboratory.
- (5) Unless otherwise specified in the Policy, referral letter by a physician other than the specialist physician himself must be attached for specialist consultation.
- (6) No benefit is payable for the conditions listed under "**LIMITATIONS AND EXCLUSIONS**" of the master policy. Common items of which are listed on this form.
- (7) Claim payment will be subject to the terms and conditions set out in the corresponding Group policy.
- (8) Incomplete form or omission of required information may cause delay in processing.
- (9) Please make copies as necessary. Certified true copies of bills and / or receipts will be provided if specified in this form.
- (10) How to submit the claim form?
 - Fill in the claim form and sign
 - Attach the original claim receipt and / or referral letter (applicable to specialist consultation is included in the Outpatient Benefits)
 - Send to your Human Resources Department or plan administrator (if applicable)
- (11) You may logon AIA Employee Benefits Online Service through AIA.COM.HK to check your processed claim records.
- (12) 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

指引

- (1) 此申請表由受僱員 / 成員以正楷填寫，每表只限一位賠償申請人（即病者）使用。
- (2) 門診 / 牙科費用賠償應於**九十日內**申請。否則賠償會被拒絕接受辦理。
- (3) 須附詳細門診費用賬單或收據正本，提供診治日期，病者姓名，病症，費用分項，治療類別及主治醫生 / 主治牙科醫生之印鑑及簽署。
- (4) 申請賠償購買藥物及 / 或X光 / 及 / 或醫學檢驗費用須附具主診醫生之處方及 / 或認可及 / 或藥房或化驗室之賬單或收據正本。
- (5) 除保單內另有註明，專科賠償必須附上由普通科醫生轉介之轉薦信。
- (6) 如費用原於保單內所列的「**限制情況和不保事項**」恕不受保。本申請賠償表所列之一些普遍“限制條款”恕不受保。
- (7) 一切賠償款項將根據有關保單上的條文計算。
- (8) 若此申請表未完全填妥或未有提供足夠理賠資料，賠償處理將被延誤。
- (9) 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。
- (10) 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及 / 或轉薦信（適用於門診福利下之專科之醫療服務）
 - 交回貴公司人事部或有關負責人（如適用）
- (11) 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。
- (12) 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樓友邦保險企業業務
澳門友邦保險辦事處：澳門商業大馬路251A-301號友邦廣場1903室友邦保險企業業務

BASIC LIMITATIONS

No benefit is payable for the following items (*unless specifically included under Outpatient Benefits):

- (a) Treatment by any person other than a physician in western medicine.
- (b) Medicines / drugs purchased and X-ray examinations or laboratory tests taken, unless the expenses incurred are as a result of clinical consultations for which benefits are payable under the policy and are supported by a physician's medicine prescription and / or recommendation.
- (c) Congenital anomalies; treatment relating to birth control sterility or infertility, sterilization of either sex.
- (d)* Condition or treatment related to and / or resulting from pregnancy.
- (e) Treatment of psychological or emotional conditions; rest cures or sanitarium care; drug addiction or alcoholism.
- (f)* Any dental care or treatment or surgery unless necessitated by damage to sound natural teeth as a result of an accident.
- (g)* General physical or medical check-up; eye refractions; fitting of glasses, contact lenses or hearing aids.
- (h) Cosmetic treatment or surgery for purpose of beautification or plastic surgery.
- (i)* Chiropractic Services.
- (j) Non-medically necessary treatment.
- (k) Other exclusions as stated in the Policy.

基本限制條款

下列各項不在受保範圍之內（*除特別於門診福利下列明例外）：

- (a) 非註冊西醫所作之治療。
- (b) 非註冊西醫處方購買之藥物或非經註冊西醫認可之X光檢查或醫學檢驗。
- (c) 先天性異常；節育或不育之治療；絕育手術。
- (d)* 懷孕引致之情況或治療。
- (e) 有關心理或情緒的治療；休養或療養；濫用藥物或酗酒的治療。
- (f)* 任何牙科治療或手術，但因意外導致健全的天然牙齒損傷而需要牙科治療或手術者除外。
- (g)* 例行體格檢查；屈光；配眼鏡或助聽器。
- (h) 美容治療或整容手術。
- (i)* 脊醫治療。
- (j) 非醫療所需的服務。
- (k) 保單內其他不受保障項目。

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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 immune 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.

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、病假紀錄、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紀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) 友邦保險或任何其他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。

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.

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，請在左列一欄劃上✓。

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.

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
MM	月	DD	日	YYYY	年

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)



Change of Contact Information 更改通訊資料

To provide or change your contact information, please complete this part in English and **BLOCK LETTERS**, and send to:
如需更改通訊資料，請以**英文正楷**填寫以下表格，並交回：

AIA address in HK: AIA International Limited, AIA Corporate Solutions,
友邦香港辦事處 12/F, AIA Financial Centre, 712 Prince Edward Road East, Kowloon, Hong Kong
香港九龍太子道東712號友邦九龍金融中心12樓友邦保險企業業務

AIA address in Macau: AIA International Limited, AIA Corporate Solutions,
澳門友邦保險辦事處 1903, AIA Tower, Nos. 251A-301 Avenida Commercial de Macau, Macau
澳門商業大馬路251A-301號友邦廣場1903室友邦保險企業業務

Group Policy Number: _____ Name of Insured Employee:
團體保單編號 _____ 受保僱員姓名 _____

Certificate / Employee No. of the Insured Employee / Claimant Member ID
(10 digits no. shown in the medical card)*
受保證書 / 僱員編號 / 賠償申請人成員號碼 (醫療卡上顯示的十位數字)

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Applicable for correspondence sent to Insured Employee 只適用於文件寄予受保僱員：

New Address 新地址：

Effective Date of the change 生效日期：

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MM月 DD日 YYYY年

Tel 電話：(Office 公司)

(Home 住宅)

Signature of Insured Employee
受保僱員簽署

Date Signed
簽署日期：

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MM月 DD日 YYYY年