



**American International Assurance  
Company (Bermuda) Limited**  
(Incorporated in Bermuda  
with limited liability)

**CRITICAL ILLNESS CLAIM FORM 危疾保障賠償申請表**

Agency Name / Area Code  
業務代表組別 / 區域編號 \_\_\_\_\_

Representative Name / Code  
業務代表姓名 / 編號 \_\_\_\_\_

Broker/IFA Name / Code  
保險顧問/投資顧問名稱/編號 \_\_\_\_\_

Contact Phone No.  
聯絡電話號碼 \_\_\_\_\_

**PART I (TO BE COMPLETED BY INSURED / CLAIMANT) 第一部份(由受保人或申請人填寫)**

Policy No. 保單號碼	Name of Insured 受保人姓名	This is a: 這次是:
		<input type="checkbox"/> New Claim 首次索償 <input type="checkbox"/> Further Claim 再次索償 <input type="checkbox"/> Review / Appeal 重批/覆核
	I.D. Card/Passport No. 身分證/護照號碼	Contact Phone No. 聯絡電話號碼
Correspondence Address 聯絡地址		

**NATURE OF CLAIM AND RELATED DETAILS 賠償性質及有關資料:**

1. Name the critical illness you are claiming for 申請賠償的危疾名稱	1.						
2. Date of first consultation 首次求診日期	2. <table border="1"><tr><td> </td><td> </td><td> </td></tr><tr><td>(MM 月/</td><td>DD 日/</td><td>YYYY 年)</td></tr></table>				(MM 月/	DD 日/	YYYY 年)
(MM 月/	DD 日/	YYYY 年)					
3. Describe the symptoms from date of onset 詳述病發日起所患之一切病徵	3.						
4. The name, address and contact phone no. of the doctor you first consulted for this illness 首次就此病而求診之醫生姓名, 地址及聯絡電話	4.						
5. How long have you been having these symptoms from the date of your first consultation? 閣下在首次求診日起, 以上的病徵已存在多久?	5.						
6. The name, address and contact phone no. of your regular doctor 閣下慣常求診之醫生姓名, 地址及聯絡電話	6.						

This form is applicable for making claims against the policies issued by American International Assurance Company, Limited / American International Assurance Company (Bermuda) Limited (hereinafter called "AIA/AIAB", whichever is applicable).

此表格適用於美國友邦保險有限公司/美國友邦保險(百慕達)有限公司  
(以下簡稱“友邦保險”, 視何者適合而定) 繕發之保單的索償申請。

Policy Number 保單號碼

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**RECORD OF MEDICAL CONSULTATION / HOSPITALIZATION 過往之求診及住院記錄：**

7. Please give below the details of any doctor(s) who have been consulted in connection with this illness.  
請提供曾診治此病之其他醫生或專科醫生資料。

Name 姓名	Address 地址	Date (MM/DD/YYYY) 求診日期 (月/日/年)
a.		
b.		
c.		

8. Please give below the details of any hospitalization in connection with this illness.  
請提供與此病有關之住院記錄。

Name of Hospital 醫院名稱	Date of Admission (MM/DD/YYYY) 入院日期 (月/日/年)	Date of Discharge (MM/DD/YYYY) 出院日期 (月/日/年)
a.		
b.		
c.		

**GENERAL 其他資料：**

9. Have any of your blood relatives suffered from a similar or related illness? If "yes", please state.  
直係親屬中有否曾患有相同或有關之危疾？如“有”，請填寫下欄。

Relationship of Relative 親屬關係	Nature of Illness 危疾類別	Date Illness Diagnosed (MM/DD/YYYY) 診斷日期 (月/日/年)
a.		
b.		
c.		

10. Are there any other illnesses/complaints treated for or suffered by you prior to this critical illness you are claiming for? If so, please give full details.  
閣下在患有是次申請賠償之疾病前是否患有其它疾病？如“有”，請把有關資料詳細填報。

Name of Hospital 醫院名稱	Date of Admission (MM/DD/YYYY) 入院日期 (月/日/年)	Date of Discharge (MM/DD/YYYY) 出院日期 (月/日/年)
a.		
b.		
c.		

11. Are you insured for similar benefits with any other Company? If "yes", please state.  
閣下是否在其它公司投保類似危疾保障？如“有”，請填寫下欄。

Name of Insurer 投保公司名稱	Type / Amount of Benefit 投保類別/金額	Policy Number 保單號碼
a.		
b.		
c.		

Policy Number 保單號碼

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**AMERICAN INTERNATIONAL ASSURANCE COMPANY (BERMUDA) LIMITED**  
**美國友邦保險 (百慕達) 有限公司**  
**AMERICAN INTERNATIONAL ASSURANCE COMPANY, LIMITED**  
**美國友邦保險有限公司**

(hereinafter called "AIA/AIAB", whichever is applicable 以下簡稱 "友邦保險", 視何者適合而定)

**DECLARATION AND AUTHORIZATION 聲明及授權**

I/We DECLARE that the answers given above are true and complete.

本人/我們現聲明以上每一項答案為完全和真確。

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 application or collected, obtained, compiled or held by AIA/AIAB by any means from time to time may be used, maintained, processed, stored, transferred, disclosed and/or shared by AIA/AIAB for the purposes of processing, administering, implementing and effecting the requests or transactions contemplated in this application or any other applications made by me/us from time to time, promoting or providing subsequent or other services or products to me/us, direct marketing, data matching and/or communicating with me/us. I/We further DECLARE and AGREE that AIA/AIAB may transfer, disclose, grant access of or share such personal data and other information to or with individuals, entities and/or organizations associated with AIA/AIAB and/or to or with third parties (including, without limitation, reinsurance companies, claims investigation companies, industry associations or federations, fund management companies, financial institutions, or service providers) selected by AIA/AIAB, in each case whether within or outside of Hong Kong (applicable to policies issued in Hong Kong/Macau (applicable to policies issued in Macau), for any of the aforesaid purposes and/or for the purposes of providing administrative, data processing, data maintenance or storage, telecommunications, computer, payment or other services to AIA/AIAB in connection with the operation of its business. I/We understand that I/we have the right to obtain access to and to request correction of my/our personal data held or controlled by AIA/AIAB. Such request can be made to any of AIA/AIAB's Customer Service Centres. If I/we do not wish to receive marketing information or materials, I/we will send an opt-out notice to AIA/AIAB, in which case my/our personal data and other information would be included in a centralized customer opt-out list that may be shared amongst AIA/AIAB's associated partners for reference.

本人/我們現聲明並同意友邦保險可使用、保留、處理、儲存、轉交、透露及/或共用友邦保險所收集、索取、整理或保留在此申請表所載或從其他途徑取得之任何有關本人/我們的個人資料或其他有關本人/我們的保單或投資資料, 用作處理、管理、落實及實行在此申請表所載或本人/我們從任何其他申請表所提出之要求, 及介紹或提供其稍後或其他的服務或產品予本人/我們、直接促銷、資料核對及/或聯絡本人/我們之用途。本人/我們再聲明並同意友邦保險可向與友邦保險有關的香港 (適用於香港簽發之保單)/澳門 (適用於澳門簽發之保單) 或海外的人士、團體及/或機構及/或任何被選的第三機構 (包括並不限於再保險及賠償調查公司, 及有關的行業協會/聯會、基金管理公司、金融機構或提供有關服務之公司) 轉交、透露、授權取得或共用本人/我們之個人或其他資料, 用作以上列明之用途及/或友邦保險業務運作之用, 包括行政、資料處理、資料保存或儲存、通訊、電腦、付款或其他服務。本人/我們明白到本人/我們有權向友邦保險查閱及申請更改友邦保險儲存或管理與本人/我們有關的個人資料。有關的申請可於友邦保險任何一間客戶服務中心辦理。若本人/我們不想收到友邦保險的銷售資料或刊物, 本人/我們會發出信函通知友邦保險, 而本人/我們的個人或其他資料會存於友邦保險之中央資料檔內的非聯絡客戶名單, 並會供友邦保險及有關人士/機構作參考。

I/We hereby irrevocably authorize:

- any organization, institution, or individual that has any record or knowledge of my/our/the Insured's employment, sick leave records, accident or loss details (of any sorts), health, medical history or any treatment or advice, that when requested by an authorized representative of AIA/AIAB may disclose any such information. This authorization shall bind my/our/the Insured's successors and assigns and remain valid notwithstanding my/our/the Insured's death or incapacity in so far as legally possible. A photocopy of this authorization shall be as valid as the original.
- AIA/AIAB or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests to underwrite and evaluate my/our/the Insured'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 immunodeficiency syndrome (AIDS), infection by any human immunodeficiency virus (HIV), immune disorder or the presence of medications, drugs, nicotine or their metabolites.

本人/我們茲授權:

- 任何知悉或擁有本人/我們/被保人之工作、病歷記錄、意外或損失 (任何類別) 之詳情、健康狀況、病歷或任何治療或諮詢記錄及曾為或將為本人/我們/被保人診治之機構、組織或人士、向友邦保險透露有關資料, 不得撤回, 即使本人/我們/被保人死亡或喪失能力, 此授權書仍然存有法律效力, 而本人/我們/被保人之繼承人及轉讓亦會受此授權書約束。此授權書之正本與副本同屬有效。
- 友邦保險或任何其認可之驗身醫生或化驗所, 替本人/我們/被保人進行所需之醫療評估及測試, 並對本人/我們/被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脂肪、糖尿病、腎或肝功能失常、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、尼古丁及其代產品之含量等化驗。

**Check Settlement Option 支票賠償方法**

Hong Kong Dollar 港元

Policy Currency 保單貨幣

- I/We understand that any benefits payable under the Policy will be paid in the latest policy currency as shown on the Policy Information Page of the Policy or, if applicable, the appropriate subsequent endorsement. Accordingly, the provision of the option to receive any such benefits in a currency other than the latest policy currency (the "Opted Currency") is solely a service offered by AIA/AIAB at its discretion.
  - I/We understand and agree that should I/we opt for payment of any benefits payable under the Policy in the Opted Currency, I/we will bear the necessary exchange difference, such difference being determined by AIA/AIAB on the basis of AIA/AIAB's internal exchange rates as at the time of the relevant currency conversion.
- 本人/我們明白所有保單利益之款項將根據保單資料頁或隨後所發出之批註 (如適用) 所載之最近期保單貨幣為準。因此, 提供選擇以最近期的保單貨幣以外的貨幣 ("選擇貨幣") 作為收取任何此等利益的貨幣只屬友邦保險酌情所提供的服務。
  - 本人/我們明白及同意如本人/我們選擇任何保單下所作出的利益款項以 "選擇貨幣" 支付, 本人/我們同意承擔所需的兌換差額, 而該差額是有關貨幣兌換時依據友邦保險內部貨幣兌換率而釐定。

**Important Note 注意事項**

- In order to speed up your claim application, please attach the required claims documents together with this application form. You may check the required documents as stated in this application form "Claims Document Checklist".
  - In case you want to claim for other benefits such as disability benefits, you have to complete an appropriate claim form of that respective claim type and file it in together with the necessary supporting evidence.
- 為使能儘速辦理您的索償申請, 請將此表格連同有關索償文件一併遞交。有關申請索償所需遞交之文件, 請參閱此表格之 "索償文件參考表"。
  - 如您還需申請其他賠償類別, 如傷殘, 您須另行填寫及遞交相關的索償申請表格和所需證明。

Signature of Witness  
見證人簽署

Name 姓名:

Date 日期:

Signature of Insured/Claimant 受保人/申請人簽署  
(Please do not sign on blank form and use the signature on our file  
請勿在空白表格上簽署, 並確保簽名與保單申請書一致)

Name 姓名:

I.D. Card/Passport Number 身分證/護照號碼:

Date 日期:

This declaration and authorization must be signed by the insured. If the insured is a minor, the insured's parent/legal guardian can sign on his/her behalf.

此聲明及授權書必須由受保人簽署, 若受保人為小童, 則可由其家長/合法監護人簽署。

Please complete the following information if the signature is not given by the insured. 若簽署者非受保人, 請填寫下列資料。

Name of Insured 受保人姓名 (in block letter 正楷書寫)

Relationship with the Insured 與受保人關係

(Please provide documentary proof for the relationship. 請提交關係證明文件)

Countersign by Agency Leader  
營業員經理簽名

Date  
日期

Policy Number 保單號碼

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**CLAIMS DOCUMENT CHECKLIST 索償文件參考表**

Please attach the following documents together with this application form and kindly tick against the documents submitted with this form. 請將此表格連同以下文件遞交，並於提交的文件欄內畫上“X”號。

- Histopathological Report 病理檢驗報告
- Confidential Medical Certificate for your claimed critical illness or performed surgery 您所索償的危疾或有關手術的危疾保障賠償醫生報告
- Laboratory, Ultrasonogram, X-Ray and/or MRI Report(s) 化驗、超聲波、X-光、電腦掃描及磁力共振報告
- Hospital Discharge Summary / Sick Leave Certificate with Diagnosis 出院總結/列有診斷證明之病假證明書
- Patient Card Copy of Consulted Doctor(s) 醫生覆診卡副本

We will notify you or our AIA representative/your broker/IFA if we need to obtain extra information from you or from outside parties to assess your claim. As the time required for obtaining the information is variable, the processing time of your claim will likely be longer. 若我們有需要就審核閣下之賠償申請向您或其他人士索取額外資料，我們會通知閣下或友邦業務代表/您的保險顧問/投資顧問。因索取有關資料需時，賠償申請的審核時間會較長。