



TOTAL & PERMANENT DISABILITY CLAIM FORM
完全及永久喪失工作能力賠償申請表

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	<input type="checkbox"/> Please apply this claim to all my policies with the same benefit. 請把是次索償申請應用於本人於貴公司所持有之所有同類保障之保單 <input type="checkbox"/> Please apply this claim to the following policy / policies with the same benefit. 是次索償申請只應用於下列有同類保障之保單： <i>Remarks 註:</i> <i>Please take the appropriate box; otherwise we will apply this claim to all of your policies held with our Company. 請選擇適用者，否則我們將把是次索償申請應用於閣下於本公司所持有之所有同類保障。</i>	
Name of Insured 受保人姓名	ID Card / Passport No. 身分證/護照號碼	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
	Contact Phone No. 聯絡電話號碼	
Correspondence Address 聯絡地址		

QUALIFICATIONS AND EMPLOYMENT PARTICULARS 學歷及就業詳情:

1. Your academic qualification, qualified knowledge and training. 閣下之學歷、認可知識及訓練。	1.						
2. Occupation (if more than one, state all) and exact nature of occupational duties before disability. 現職(倘有兼職請列明)職位及職責	2.						
3. Name and address of business and employer. 公司或僱主名稱及地址	3.						
4. Did you file a sick leave certificate with your employer? 有否向僱主遞交病假證明書?	4. <input type="checkbox"/> Yes 有 <input type="checkbox"/> No 沒有						
5. Date you last worked: 最後工作日期	5. <table border="1" style="margin-left: auto; margin-right: auto;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center;">(MM /月</td><td style="text-align: center;">DD /日</td><td style="text-align: center;">YY /年)</td></tr></table>				(MM /月	DD /日	YY /年)
(MM /月	DD /日	YY /年)					
6. Date you returned to work (If no, then give expected date of return.) 何時恢復工作(如否, 祈望何時可恢復工作)	6. <table border="1" style="margin-left: auto; margin-right: auto;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center;">(MM /月</td><td style="text-align: center;">DD /日</td><td style="text-align: center;">YY /年)</td></tr></table>				(MM /月	DD /日	YY /年)
(MM /月	DD /日	YY /年)					

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) 續發之保單的索償申請。

Policy Number 保單號碼

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PART II (TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SURGEON AT THE CLAIMANT'S OWN EXPENSES)

第二部份由受保人自費由主診醫生或手術醫生填寫

Name of Patient: _____
病者姓名

ID Card / Passport No: _____
身分證/護照號碼

(A) HISTORY & DIAGNOSIS 病歷及診斷														
1. The date when symptoms first appeared or accident happened 病徵首次出現/意外發生日期	<table border="1"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td>M</td><td>M</td><td>D</td><td>D</td><td>Y</td><td>Y</td></tr> </table>							M	M	D	D	Y	Y	2. Symptoms and complaints presented by the insured 受保人主訴之病徵或徵狀
M	M	D	D	Y	Y									
3. The date of first consultation 首次求診日期	<table border="1"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td>M</td><td>M</td><td>D</td><td>D</td><td>Y</td><td>Y</td></tr> </table>							M	M	D	D	Y	Y	4. Clinical and physical findings during first consultation 有關疾病/意外之初次診斷結果
M	M	D	D	Y	Y									
5. The date when the diagnosis was first given 首次診斷日期	<table border="1"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td>M</td><td>M</td><td>D</td><td>D</td><td>Y</td><td>Y</td></tr> </table>							M	M	D	D	Y	Y	6. The final diagnosis of the condition and its complications 最後診斷結果及其併發症
M	M	D	D	Y	Y									
7. The academic qualification, qualified knowledge and training as declared by the Insured 受保人所申報之學歷、認可知識及訓練		8. Insured's occupation (if more than one, state all) and exact nature of occupational duties before disability. 受保人之現職(倘有兼職請列明)職位及職責。												
9. The date the insured was first absent from work due to the condition 受保人首次就有關疾病/意外停止工作之日期	<table border="1"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td>M</td><td>M</td><td>D</td><td>D</td><td>Y</td><td>Y</td></tr> </table>							M	M	D	D	Y	Y	10. Has patient ever had same or similar condition? If so, please state when and give details. 受保人是否有類同之病歷? 如“有”,請說明何時及詳述細節。
M	M	D	D	Y	Y									
11. Details of consultations and treatment rendered by you / hospital 由閣下/貴院提供之治療詳情:														
Date/Period 日期/時期	Details of Treatment 治療詳情	Investigation/Special Procedures 檢驗/特殊醫療程序												
12. Name and address of other doctors/hospitals attended for treatment of this condition 受保人就有關疾病/意外曾求診之醫生姓名及地址														
Date of treatment 治療日期	Physician/Hospital attended 求診醫生姓名/醫院名稱	Address 地址												

(B) CURRENT HEALTH CONDITIONS OF THE INSURED 受保人現時之健康狀況	
1. Progress of recovery 康復進展	<input type="checkbox"/> Recovered 已完全康復 <input type="checkbox"/> Improving 康復中 <input type="checkbox"/> Static 情況穩定 <input type="checkbox"/> Retrogressed 情況惡化 Remarks 註:
2. Current state of mobility. 日常活動概況 Give name of hospital and the period of hospital confinement, if any 如需住院,請提供醫院名稱及住院日期	<input type="checkbox"/> Ambulatory 行動自如 <input type="checkbox"/> Home confined 需留在家中休息 <input type="checkbox"/> Bed confined 需臥床休息 <input type="checkbox"/> Hospital confined 需留院治療 Remarks 註:
3. Please describe the current physical impairment 請詳述受保人現時之身體缺陷/損害情況	

Policy Number 保單號碼

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<p>4. Can the insured perform the right listed "Activities of Daily Living" without the use of mechanical equipment, special devices or other aids and adaptations? 按日常生活活動評估，受保人在不受輔助下，可否完成右列的事項？</p>	<p>Transfer (to get in bed and out of bed or chair) 上下床或從椅子坐起： <input type="checkbox"/> can 可以 <input type="checkbox"/> cannot 不可以</p> <p>Mobility 行動： <input type="checkbox"/> can 可以 <input type="checkbox"/> cannot 不可以</p> <p>Dressing 穿衣： <input type="checkbox"/> can 可以 <input type="checkbox"/> cannot 不可以</p> <p>Bathing & Washing 洗澡及梳洗： <input type="checkbox"/> can 可以 <input type="checkbox"/> cannot 不可以</p> <p>Eating 進食： <input type="checkbox"/> can 可以 <input type="checkbox"/> cannot 不可以</p> <p>Toileting 如廁： <input type="checkbox"/> can 可以 <input type="checkbox"/> cannot 不可以</p> <p>Remarks 註：</p>
<p>5. With the current health condition of the Insured in mind, what would you rate the present working capacity of the insured? 就受保人現時之健康狀況而言，請評估其工作能力。</p>	<p><input type="checkbox"/> No limitation of functional capacity, capable of heavy work without restrictions 能夠從事任何體力勞動工作</p> <p><input type="checkbox"/> Capable of medium manual activity 能夠從事中度體力勞動工作</p> <p><input type="checkbox"/> Slight limitation of functional capacity, capable of light work 只可從事輕度體力勞動工作</p> <p><input type="checkbox"/> Moderate limitation of functional capacity, capable of clerical / administrative activity 只可從事非體力勞動或文書工作</p> <p><input type="checkbox"/> Severe limitation of functional capacity, incapable of minimum activity 不可從事任何體力勞動甚或文書工作</p> <p>Remarks 註：</p>
<p>6. Please describe the current mental impairment of the Insured (if normal, please go to Part C) 請詳述受保人現時之精神缺陷/損害程度（如精神狀況良好，請填寫 C 部份）</p>	
<p>7. With the current mental status of the Insured as described above, what would you rate the present ability for interpersonal relations and communication of the insured? 就受保人現時之精神狀況而言，請評估其社交活動及溝通能力。</p>	<p><input type="checkbox"/> Able to engage in all interpersonal relations and communication (without limitations) 社交活動及溝通能力均為完全正常</p> <p><input type="checkbox"/> Able to engage in most interpersonal relations and communication (slight limitations) 能應付大部份社交活動及與人溝通</p> <p><input type="checkbox"/> Able to engage in only limited interpersonal relations and communication (moderate limitations) 只能有限度地參加社交活動及與人溝通</p> <p><input type="checkbox"/> Unable to engage in interpersonal relations and communication (marked limitations) 嚴重缺乏社交活動及溝通能力</p> <p><input type="checkbox"/> Has significant loss of psychological, physiological, personal and social adjustment (severe limitations) 嚴重缺乏心理、生理、個人及社會適應能力</p> <p>Remarks 註：</p>

(C) PROGNOSIS & REHABILITATION 進展及康復

<p>¹ Is the insured now totally disabled? 受保人現時是否完全喪失工作能力？</p>	<p>In terms of his/her own job: 根據受保人本身之工作或職業而言： <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p>	<p>In terms of any other jobs: 就從事或參與其他工作或職業而言： <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p>
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