



**DISMEMBERMENT CLAIM FORM**  
**斷肢賠償申請表**

Operations Team  
營運組別

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		

**EMPLOYMENT PARTICULARS 就業詳情:**

1. 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	1.						
2. Name and address of business or employer. 公司或僱主名稱及地址	2.						
3. Did you file a sick leave certificate with your employer? 有否向僱主遞交病假證明書?	3. <input type="checkbox"/> Yes 有 <input type="checkbox"/> No 沒有						
4. Did you submit a claim for workmen's compensation for this accident? 有否就此意外申請勞工賠償?	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"><tr><td> </td><td> </td><td> </td></tr><tr><td>(MM/月</td><td>DD/日</td><td>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"><tr><td> </td><td> </td><td> </td></tr><tr><td>(MM/月</td><td>DD/日</td><td>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。













