



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

INDIVIDUAL HOSPITALIZATION CLAIM FORM 住院賠償申請書

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

This form is generated via the telephone enquiry system "AIA Enquiry Express" / "EasyTouch" or "AIA Corporate Website" and is applicable to relevant applications.
此表格乃透過電話系統"友邦查詢快線"/"友邦一線通查詢快線"或"AIA企業網站"編印, 並適用於有關申請。

Policy Number 保單號碼 (This policy number will be treated as the reference number for the issues related to this claim. 此保單號碼會被用作有關是次索償事項之參考號碼。)	
Name of Insured 受保人姓名	I. D. Card/Passport Number 身分證/護照號碼

Agent/Broker's Name 營業員/經紀姓名	Agent/Broker Code 營業員/經紀號碼
Agent/Broker's Tel. No. 營業員/經紀聯絡電話	Agency/Broker Name/Area Code 營業員/經紀組別/區域編號

Correspondence Address 通訊地址	Contact Phone No. 聯絡電話
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Benefits to Claim 索償類別 HS/IMP HB / HI Maternity Benefit AI/WI PA VGA Group PA

This case is a 本個案為:
 New Claim 首次索償 Further Claim 再度索償 Pending Claim 待決賠償 Review/Appeal 重批/覆核

Are you making any other insurance or compensation claim as a result of this treatment?
 有關是次治療, 閣下有否向其他保險公司/機構申請賠償? No 沒有 Yes 有

If yes, please provide the below information. 如有, 請提供下列資料。
 Name of insurance company/organization: 保險公司/機構名稱: _____ Policy No./Membership No.: 保單/會員編號: _____

<p>PLEASE COMPLETE QUESTIONS 1 TO 5 AND 8 TO 11 IF HOSPITALIZATION WAS DUE TO ACCIDENT 因意外受傷入院請填寫問題1至5及8至11</p> <p>1. Date and time of accident 意外日期及時間 _____ : _____ <input type="checkbox"/> A.M. 上午 MM月 / DD日 / YYYY年 HR時 MIN分 <input type="checkbox"/> P.M. 下午</p> <p>2. Where and how did it happen 意外地點及經過</p> <p>3. Part of body injured and type of injury 受傷部位及傷勢</p> <p>4. Present occupation (if more than one, state all) and exact nature of occupational duties 現職 (若有兼職請列明) 職位及職責</p> <p>5. Name and address of business or employer 公司或僱主名稱及地址</p>	<p>(b) The doctor who referred the insured to hospital/other doctors seen for this or similar past condition 建議入院的醫生資料/其他曾診治此病或過往同類病況的醫生資料</p> <p>Name and address of doctor/hospital 醫生/醫院名稱及地址 _____ Date 求診日期 _____</p>
<p>PLEASE COMPLETE QUESTIONS 6 TO 11 IF HOSPITALIZATION WAS DUE TO ILLNESS 因病入院請填寫問題6至11</p> <p>6. Give a brief description of symptoms 描述病徵及病狀</p> <p>7. How long have these symptoms existed prior to the first consultation? 該等病徵在首次求診前已存在多久?</p> <p>8. Give details of consultations 診治詳情 (a) The doctor first consulted for this illness 首次就診的醫生資料 Date 求診日期 _____ MM月 / DD日 / YYYY年 Name and address of doctor/ hospital 醫生/醫院名稱及地址</p>	<p>9. (a) Please give the date of admission and the date of discharge. 請提供入院及出院日期。 Date of Admission 入院日期 _____ Date of Discharge 出院日期 _____ MM月 / DD日 / YYYY年 MM月 / DD日 / YYYY年</p> <p>(b) Have you taken any home leave during the hospital confinement? 您有否於住院期間請假外出? <input type="checkbox"/> No 沒有 <input type="checkbox"/> Yes 有 If Yes, please state the date and time of your home leave. 如有, 請列明外出之日期及時間。</p>
	<p>10. Any relationship between the Registered Medical Practitioner/ Medical Services Provider and Insured / Claimant / Agent / Broker? If so, please state the relationship. 若就診之註冊醫生/醫療服務提供者與受保人/索償人/保險營業員/保險經紀有任何關係, 請列明之:</p> <p>11. Other information 其它資料</p>

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PART II TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SURGEON AT THE CLAIMANT'S OWN EXPENSES
 第二部份申請人自費由主診醫生/手術醫生填寫

<p>1. (a) Name of patient 病人姓名</p> <p>(b) I.D. Card / Passport Number 身分證/護照號碼</p> <p>(c) Age 年齡 (d) Sex 性別</p>	<p>9. Brief discharge summary (including treatments, investigation procedures, results and/or any complications and follow up plan) 出院撮要：(治療及以後治療計劃，包括診查辦法、結果，併發症及跟進計劃)</p>
<p>2. Hospitalization 住院</p> <p>Name of hospital 醫院名稱</p> <p>Date of Admission 入院日期 Date of Discharge 出院日期</p> <p>MM月 / DD日 / YYYY年 MM月 / DD日 / YYYY年</p> <p>Period in Intensive Care Unit 入住深切治療部日期</p> <p>From MM月 / DD日 / YYYY年 To MM月 / DD日 / YYYY年</p>	<p>10. To the best of your knowledge, has the patient ever had the same or similar conditions or symptoms relating thereto? 據閣下所知，病人以前有沒有患有同類病況？</p> <p><input type="checkbox"/> No 沒有 <input type="checkbox"/> Yes 有</p> <p>If yes, please state dates and details. 如有，請說明何時及當時情況。</p> <p>Treatment Dates 診治日期 Details 詳情 (MM月/DD日/YYYY年)</p>
<p>3. Chief complaints of the patient relating to this hospitalization/surgery 此次住院/手術的主要原因</p>	<p>11. Had the patient taken any home leave during the hospital confinement? 病人有沒有於住院期間請假外出？</p> <p><input type="checkbox"/> No 沒有 <input type="checkbox"/> Yes 有</p> <p>If Yes, please state date, time and reason of the patient's home leave. 如有，請列明外出之日期、時間及原因。</p>
<p>4. Date of the accident occurred or symptoms first appeared 首次出現病徵日期或意外發生日期</p> <p>MM月 / DD日 / YYYY年</p> <p>5. Date of first consultation for this condition or related illness 病人首次求診日期</p> <p>MM月 / DD日 / YYYY年</p>	<p>12. Was the patient referred by another doctor? 病人是不是經其他醫生轉介？</p> <p><input type="checkbox"/> No 不是 <input type="checkbox"/> Yes 是</p> <p>Name and address of the referral doctor 轉介醫生的姓名和地址</p>
<p>6. Diagnosis of conditions 診斷</p> <p>7. Surgical Procedure 手術</p> <p>Date of Operation 手術日期</p> <p>MM月 / DD日 / YYYY年</p> <p>Name of Procedure 手術名稱</p> <p>Nature 性質</p>	<p>PLEASE COMPLETE IF HOSPITALIZATION WAS DUE TO ACCIDENT 因意外受傷入院請填寫此欄</p> <p>13a. Present Condition of Injury 現時受傷情況</p> <p>b. Patient's occupation and exact nature of occupational duties. 病人之職業及職責</p> <p>c. Bearing in mind the patient's occupation, in what way do you feel the injuries would / would not totally prevent the patient from working? 以病人之職業而論，閣下認為此傷勢會不會令病人完全不能工作？請列明原因。</p>
<p>8. Present Prognosis 現時進展</p>	<p>Name of Attending Physician/ Specialist (with qualifications) 主診/專科醫生的姓名(資歷)</p> <p>Signature (with chop) 簽名(蓋印)</p> <p>Address and Telephone No. 地址及電話</p> <p>Date 日期</p>

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PART III CLAIMS DOCUMENT CHECKLIST

第三部份 索償文件參考表

Please tick against the Required Documents submitted with this application form. If you want to get back the Original Medical Receipt(s) / Sick Leave Certificate(s) submitted, please also complete the "Request for Return of Original Document(s)" Form. 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.
 請於連同此表格提交的基本文件欄內劃上“X”號。如欲退回任何呈交之正本醫療收據/病假證明書，請一併遞交『退回正本文件』申請表格。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。

Document Type 文件類別	Hospital & Surgical Benefit 住院及手術賠償	Hospitalization Benefit / Hospital Indemnity / Hospital Income Benefit 住院惠益 / 住院償金
<input type="checkbox"/> Owner's ID Copy 保單持有人的身分證副本	✓	✓
<input type="checkbox"/> Individual Hospitalization Claim Form - Part 2 (OPCLMF03) 住院賠償申請書 - 第二部份 (OPCLMF03)	✓	✓
<input type="checkbox"/> Laboratory/X-Ray/CT Scan/MRI/Pathological Report(s) 化驗/X-光/電腦掃描/磁力共震/病理檢驗報告	✓	✓
<input type="checkbox"/> Original Medical/Hospital Receipts and Statement of Charges (Claimed Amt: _____) 醫院、醫療收據/收費單正本 (索償金額: _____)	✓	*
<input type="checkbox"/> Hospital Discharge Summary/Sick Leave Cert with clear Diagnosis (Period: From _____ To _____) 出院總結/列有診斷證明之病假證明書 (時段: 由_____至_____)	*	✓
<input type="checkbox"/> Photocopy of Hospital Receipt and Statement of Charges 醫院、醫療收據/收費單副本	*	✓
<input type="checkbox"/> Compensation Breakdown from other Insurer/Party 其他保險公司或機構之賠償細算表	✓	*
<input type="checkbox"/> Request for Return of Original Document(s) (OPUAI28) 退回正本文件申請表格 (OPUAI28)	*	*
<input type="checkbox"/> Individual Life & Group Claims Arrangement Form (OPCLMF61) 壽險及團體賠償安排表格 (OPCLMF61)	*	*
<input type="checkbox"/> Photocopy of New Born Baby's Birth Certificate/Other Supporting Documents (Only applicable for Maternity Benefit Claim) 初生嬰兒出世紙/其他出生證明文件副本 (只適用於分娩惠益索償)	*	*
✓ Required Documents 基本文件	* Optional Documents 附加文件	