



Medical Claim Form

醫療賠償申請表



If claim application can be done through AIA+ mobile app, there is no need to complete the PART I of this claim form. Please contact your attending doctor to complete PART II of this claim form.

若透過 AIA+ 手機程式遞交申請索償，無需填寫此賠償申請表的第一部分。閣下可進一步安排主診醫生填寫賠償申請表第二部分。

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

Policy Number 保單號碼	Name of Insured 受保人姓名	ID Card Number / Passport Number 身份證號碼 / 護照號碼
<input type="text"/>	<input type="text"/>	<input type="text" value="XXXX"/>

Please specify one of the following persons to follow up on this claim. 請指定以下人士之一負責跟進此索償申請。

- By servicing agent as policy record 保單記錄中的營業員
 By other agent / broker / IFA / TR of below details: 其他營業員 / 保險經紀或獨立理財顧問 / 業務代表，資料如下：



01002179

Area Code 區域編號	Agency / Broker Name 營業員組別 / 經紀名稱	Agent / Broker Code 營業員號碼 / 經紀號碼
<input type="text"/>	<input type="text"/>	<input type="text"/>
Agency Code 營業員組別編號	Agent / TR's Name 營業員 / 業務代表姓名	Agent / TR's Tel. No. 營業員 / 業務代表聯絡電話
<input type="text"/>	<input type="text"/>	<input type="text"/>

TR Membership Number 業務代表會員號碼 IA ANG

- By policy owner 保單持有人

For proper follow up on your claims progress, your AIA financial planner / broker / IFA of your latest inforce policy can view this claim's information if no specific agent / broker / IFA / TR information is provided at above. 為了妥善地跟進您的賠償進度，若於以上沒有提供指定營業員 / 保險經紀或獨立理財顧問 / 業務代表資料，您最新生效保單的友邦保險財務策劃顧問 / 保險經紀或獨立理財顧問將能夠查閱是次申請資料。

If you do not agree on the above arrangement, please mark a "X" in the box. 如果您不同意上述安排，請於空格內劃上「X」號。

Benefits to Claim 索償類別

- Accident Medical Reimbursement 意外醫療費用賠償 Medical Reimbursement 醫療費用賠償 Health Wallet 健康賞
 Accident / Weekly Indemnity 意外 / 每週賠償 Hospital Income / Benefit 住院入息 / 惠益
 Broken Bone 骨折惠益 Voluntary Group Assurance 自選團體保障

Remarks: Please select the appropriate box; otherwise we will assess all your eligible benefits.

註：請選擇適用者，否則我們將評估您所有符合條件的保障利益。

CLAIMS SEQUENCE 理賠次序

Please use 1, 2, and 3 to indicate the order of claim 請以 1, 2, 3 表示你所選擇的理賠順序

<input type="text" value=""/>	AIA Individual Medical Insurance 友邦個人醫療保險	<input type="text" value=""/>	AIA Group Medical Insurance 友邦團體醫療保險	<input type="text" value=""/>	Other Insurance Company 其他保險公司
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Please further provide the below information and relevant settlement advice, if applicable:
請提供以下資料及遞交有關的賠償金額通知書（如適用）：

- (I) AIA Group Medical Insurance Policy: 1) group policy no. and employer name, 2) member/certificate no., 3) employee name and 4) relationship with employee

友邦團體醫療保險保單：1) 團體保單號碼及僱主名稱、2) 會員 / 證書編號、3) 員工姓名及 4) 與員工的關係

- (II) Other insurance company: 1) name of other insurance company, 2) policy no., 3) name of insured and 4) name of policy owner
其他保險公司：1) 其他保險公司名稱、2) 保單號碼、3) 受保人姓名及 4) 保單持有人名稱

If the insured or the policyholder is holding AIA International Limited, AIA Company Limited and/or AIA Everest Life Company Limited policies, the claims (including registration of FPS / eBank-in services) will be processed together. In addition, the "Declaration and Authorization" and "Personal Information Collection and Use" in the claim form will be also applicable to AIA International Limited, AIA Company Limited and AIA Everest Life Company Limited.

若受保人或保單持有人同時持有友邦保險(國際)有限公司、友邦保險有限公司及 / 或友邦雋峰人壽有限公司之保單，相關賠償（包括登記「轉數快」或「電子入賬服務」）將會一併處理。此外，此表格內之「聲明及授權」及「個人資料收集及使用」亦同時適用於友邦保險(國際)有限公司、友邦保險有限公司及友邦雋峰人壽有限公司。

If you do not agree on the above arrangement, please mark a "X" in the box. 如果您不同意上述安排，請於空格內劃上「X」號。

AIA E-ADVICE 「友邦電子通知書」

Please mark an "X" in the box to apply for this service. 如欲申請此服務，請於空格內劃上「X」號。

Apply for Internet Service "AIA e-Advice" to view / download the softcopies via AIA+ for the above policy and any other policy numbers if specified as below, subject to the "Terms and Conditions for use of AIA+" which is available at <https://www.aia.com.hk/aia-plus/en/tnc>.

申請「友邦電子通知書」網上服務，就以上保單及其他下列保單號碼（如有）透過AIA+閱覽或下載副本，並受「AIA+使用條款及細則」之約束，有關條款及細則可於<https://www.aia.com.hk/aia-plus/zh-hk/tnc>。

* Email address

電郵地址:

Signature of Owner

持有人簽署:

Other policy number(s)

其他保單號碼:

(Not applicable to general insurance policies with policy number prefix "C".)

(不適用於保單號碼以「C」為首的一般保險保單。)

No Claim Discount (NCD) (Only Applicable to product with NCD)**無索償折扣（只適用於享有無索償折扣的產品）****Important Note 重要通知**

If a claim that arose in any previous Policy Year is eventually payable or paid by the company after the policy owner has earned the NCD and thereby paid a discounted premium, the company will use the actual number of Claims Free Years and its corresponding NCD to recalculate the actual eligible discounted premium.

若保單持有人獲得無索償折扣並已支付折扣後的保費，及後本公司若須就以往任何保單年度所出現的索償而作出應付或已付賠償，本公司將會按照實際的無索償年度及其相應的無索償折扣重新計算實際之合資格的折扣後保費。

Declaration and Authorization 聲明及授權

I / We represent that I am / We are the Owner / Assignee / Trustee / Beneficiary (as the case may be) under the policy(ies) as given on this form.

Unless marking a "X" in the above box, I / We hereby give my / our irrevocable consent to the company to deduct any balance in excess of the actual eligible discounted premium recalculated in accordance with the eligible NCD and related levy (if any) from any insurance proceeds.

本人/我們聲明，本人/我們為此索償申請表中列明的保單之持有人/受讓人/信託人/受益人（視情況而定）。除非於上列空格劃上「X」號，否則本人/我們完全同意，公司會從保險賠償金中扣除超出根據實際合資格無索償折扣所重新計算的保費金額及有關保費徵費（如適用）。

PERSONAL DATA COLLECTION AND USE 個人資料收集及使用

I / We confirm that I / we have read, understood and agreed to the Personal Information Collection Statement(s) of my / our policy issuer(s) and / or pension scheme provider(s), i.e. AIA International Limited (Hong Kong Branch), AIA International Limited (Macau Branch), AIA Company Limited and / or AIA Everest Life Company Limited, where applicable, (the "PICS") which is available for download: <https://www.aia.com.hk/en/privacy-statement-main>.

I / We declare and agree that any personal data and other information relating to me / us or my / our policy(ies), account(s) or investments contained in this application or collected, obtained, compiled or held by my / our policy issuer(s) and / or pension scheme provider(s) by any means from time to time may be collected and utilized in accordance with the PICS.

I / We acknowledge and consent to the transfer of my / our personal data to parties within or outside Hong Kong (for policy(ies) / pension scheme(s) issued in Hong Kong) or Macau (for policy(ies) / pension scheme(s) issued in Macau), as the case may be, for the purposes as set out in the PICS.

The latest version of the PICS which complies with the relevant rules and regulations is / are available for download from the above website and upon request.

我 / 我們確認我 / 我們已閱讀、明白及同意我 / 我們的保單發行人及 / 或退休金計劃服務提供者（即友邦（國際）有限公司（香港分行）、友邦（國際）有限公司（澳門分行）、友邦保險有限公司及 / 或友邦雋峰人壽有限公司（如適用））的個人資料收集聲明（「該聲明」），該聲明可在以下網址下載

<https://www.aia.com.hk/zh-hk/privacy-statement-main>。

我 / 我們聲明及同意在本申請所載或我 / 我們的保單發行人及 / 或退休金計劃服務提供者不時以任何方法收集、獲得、編製或持有的任何個人資料及關於我 / 我們的保單、帳戶或投資的其他資料，可根據該聲明收集及使用。

我 / 我們知悉及同意就該聲明所述目的轉移我 / 我們的個人資料至香港境外 / 境內（如保單 / 退休金計劃在香港發給）或澳門境外 / 境內（如保單 / 退休金計劃在澳門發給）（視乎情況而定）予該聲明所載的資料承讓人。

該聲明的符合相關守則及法規之最新版本可於以上網址下載及可供索取。

DECLARATION AND AUTHORIZATION 聲明及授權

I / We DECLARE that the answers given above are true and complete and I / we have already paid in full to the attending physicians for the medical expenses specified on the receipts which I / We am / are now submitting to AIA International Limited, AIA Company Limited and / or AIA Everest Life Company Limited (hereinafter called "Company").

本人 / 我們現聲明以上每一項答案為完全和真確及確認是次向友邦保險(國際)有限公司、友邦保險有限公司及 / 或友邦馬峰人壽有限公司 (以下簡稱「公司」) 遞交之單據乃由本人 / 我們之醫生發出, 單據所載之醫療費用經已全數繳付。

I / We hereby irrevocably authorize:

本人 / 我們茲授權 :

- (a) any organization, institution including but not limited to any hospitals / clinics under The Hospital Authority, 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 the Company 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.

任何知悉或擁有本人 / 我們 / 被保人之工作、病假紀錄、意外或損失 (任何類別) 之詳情、健康狀況、病歷或任何治療或諮詢紀錄及曾為或將為本人 / 我們 / 被保人診治之任何機構、組織包括但不限於任何醫院管理局轄下醫院 / 診所或人士、向貴公司透露有關資料, 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人亦會受此授權書約束。此授權書之正本與副本同屬有效。

- (b) The company 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.

貴公司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。

- (c) All personal information obtained herein is collected for the purpose of, (i) assessing, processing, evaluating and determining your requests of application for medical claims or services referral and (ii) analysing, investigating, approving and / or determining your claims submitted and will be transferred to AIA's authorized medical panels or its relevant associates / nominees / subsidiaries ("third party administrators"). You authorize us to transfer your personal information to the third party administrators and further give your consent to all third party administrators who / which are in receipt of your personal information that they may process your personal information and transfer all your processed personal information to us for the administration of your insurance policy and provide insurance services to you. Without your voluntary consent, personal information collected will not be transferred to the third party administrators. You can choose not to provide the personal information required, but that will result in not qualifying for receiving any of the services above.

所收集的個人資料會被用作 (i) 評估、處理、審核及釐定您的索償申請或服務轉介及 (ii) 分析、調查、批核及 / 或釐定您的索償申請之用及轉移至友邦保險授權之醫療網絡或其相關之附屬成員 / 代名人 / 附屬公司 (「第三方管理人」)。您授權我們轉移您的個人資料給予第三方管理人, 並進一步授權所有第三方管理人在收到您的個人資料後, 他們可以處理您的個人資料並將您的個人資料轉移至友邦保險作處理保單行政事宜, 並為您提供保險服務。然而所收集的個人資料未經您授權將不會轉移至該第三方管理人。您可選擇不向我們提供所需的個人資料, 惟這樣可能導致未能獲得任何上述的服務。

<p>Signature of Owner / Trustee 持有人 / 信託人簽署 (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表一致)</p>	<p>Signature of Insured, if other than Owner / Trustee 受保人簽署, 倘非 持有人 / 信託人 (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表 一致) (Whose age is 18 or above 年齡十八歲或以上必須簽署)</p>
<p>Name 姓名</p> <div style="border: 1px solid black; height: 20px;"></div>	<p>Name 姓名</p> <div style="border: 1px solid black; height: 20px;"></div>
<p>ID Card / Passport Number 身份證 / 護照號碼</p> <div style="border: 1px solid black; height: 20px;"></div>	<p>Date 日期</p> <div style="border: 1px solid black; height: 20px;"></div>
<p>ID Card / Passport Number 身份證 / 護照號碼</p> <div style="border: 1px solid black; height: 20px;"></div>	<p>Date 日期</p> <div style="border: 1px solid black; height: 20px;"></div>
<p>Relationship with the Insured 與受保人關係</p> <div style="border: 1px solid black; height: 40px;"></div>	<p>Signature of Witness 見證人簽署</p> <div style="border: 1px solid black; height: 20px;"></div>
<p>Name 姓名</p> <div style="border: 1px solid black; height: 20px;"></div>	<p>Date 日期</p> <div style="border: 1px solid black; height: 20px;"></div>

"AIA" shall refer to AIA International Limited (Incorporated in Bermuda with limited liability), AIA Company Limited (Incorporated in Hong Kong with limited liability), as the case may be, depending on the issuing company of the relevant insurance policies this form is subject to. 「AIA」或「友邦」指友邦保險(國際)有限公司 (於百慕達註冊成立之有限公司), 友邦保險有限公司 (於香港註冊成立之有限公司) (視情況而定), 具體取決於此信件相關表格的簽發公司。

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

1. (a) Name of patient 病人姓名				(c) Age 年齡			
(b) ID Card / Passport Number 身份證 / 護照號碼				(d) Sex 性別			
2. Hospitalization 住院 Name of hospital 醫院名稱: _____							
Date of Admission 入院日期		MM月	DD日	YYYY年	Date of Discharge 出院日期		MM月 DD日 YYYY年
Period in Intensive Care Unit 入住深切治療部日期		From 由	MM月 DD日 YYYY年	To 至	MM月 DD日 YYYY年		
3. Chief complaints of the patient relating to this hospitalization / surgery / investigation 此次住院 / 手術 / 檢驗的主要原因 _____							
4. Date when symptoms first appeared or date when the accident occurred 首次出現病徵日期或意外發生日期				MM月	DD日	YYYY年	
5. Date of first consultation for this condition or related illness 病人就此病症或相關疾病的首次求診日期				MM月	DD日	YYYY年	
6. Final diagnosis / Pathological diagnosis 最終診斷 / 病理診斷				ICD-10 code 國際疾病分類代碼(ICD-10)			
_____				_____			
7. Medical / Surgical Procedure 醫療 / 手術程序		Date of Operation 手術日期		MM月	DD日	YYYY年	
_____		_____		_____			
Name of Procedure 手術名稱 (please supplement with CPT code 請提供目前使用醫療服務術語代碼) _____							
If more than one surgeon, please explain role of the surgeon and justification 如多於一位醫生，請說明醫生的角色及原因 _____							
8. Please provide the surgical indications 請提供手術的臨床依據							
a. Any imaging tests / other diagnostic investigations done 是否已進行任何影像檢 / 其他診斷檢查							
<input type="checkbox"/> Yes 是 – Please provide the findings and attach copies of reports 請提供檢查結果並附上報告副本							
<input type="checkbox"/> No 否 – Please provide the reasons 請提供原因							
b. Any previous treatments have not been effective 是否曾有治療無效的情況							
<input type="checkbox"/> Yes 是 – Please provide the details and the responses 請提供治療詳情及反應							
<input type="checkbox"/> No 否 – Please provide the reasons 請提供原因							
c. Specific reasons or conditions suggesting surgery is needed 建議進行手術的具體原因或病況 _____							
9. a. Are the treatments, medical test and length of hospital stay (if applicable) directly related to current symptom, are medically necessary and recommended by the attending physician? 是次檢查、治療、及住院日數(如適用)是否和上述病徵有直接關係而且是醫療所需及由醫生建議?							
<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否, please give details 請詳述 _____							
Please answer the following questions if patient requires hospitalisation 如病人需要住院，請回答以下問題							
b. Are the medical tests and equipment / equipment for surgical procedure available <i>only in hospital</i> ? 是次檢查 / 手術所需的設備僅設置於醫院?							
<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否, please specify reasons for hospital stay 請說明住院原因 _____							
c. Can the medical tests / procedures be done on an outpatient basis / at day surgery centre? 是次檢查 / 手術可否在門診 / 日間手術中心進行?							
<input type="checkbox"/> Yes, please specify reasons for hospital stay 可以，請說明住院原因 _____							
<input type="checkbox"/> No, please specify reasons 不可以，請說明原因 _____							
d. Please indicate the clinical risks and medical reasons for hospitalisation 請註明臨床風險及須留院的醫療原因							
<input type="checkbox"/> Current health status (co-morbidity) 現時健康狀況(合併)症		Please specify 請說明					
<input type="checkbox"/> Expected higher risk at operation 預期手術時存在較高風險							
<input type="checkbox"/> Expected higher post-operative risk 預期手術後存在較高風險							
<input type="checkbox"/> Others, please specify reasons for admission and hospitalisation 其他，請註明必須入院的原因							
e. Is this a case of medical emergency? 這是否醫療緊急個案?							
<input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是, please specify 請說明 _____							

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10. Brief discharge summary (including treatments, investigation procedures, results and / or any complications and follow up plan)
出院摘要：(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)

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11. 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？ Yes 有 No 沒有

If Yes, please state dates and details 如有，請說明何時及當時情況：

--

Dates
日期

--	--

--	--

--	--	--	--

MM月

DD日

YYYY年

Treatment for the condition(s) 治療詳情

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12. Was the patient referred by another doctor?
病人是不是經其他醫生轉介？ Yes 是 No 不是

Name and address of the referral doctor 轉介醫生的姓名和地址：

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13. For cancer treatment, please provide the following 如屬癌症治療，請提供以下資料：

- a. Treatment regimen details of the patient including name of drugs, dosage, treatment delivery/ duration, frequency etc.
病人的癌症治療方案包括藥物名稱、劑量、治療方式、次數等資料

Radiotherapy: 放射性治療： Frequency 次數 _____

Treatment technique 治療技術：

Cyberknife 導航刀

Intensity Modulated Radiation Therapy (IMRT) 強度調控放射治療

MR Linac 磁力共振導航放射治療

Tomotherapy 螺旋放射治療

Volumetric Modulated Arc Therapy (VMAT) 體積旋轉調控放射治療

Others 其他 please specify details 請詳細說明 _____

Chemotherapy: 化學治療： Drug name and frequency 藥物名稱及次數 _____

Targeted therapy: 標靶治療： Drug name and frequency 藥物名稱及次數 _____

Immunotherapy: 免疫治療： Drug name and frequency 藥物名稱及次數 _____

Others 其他： please specify details 請詳細說明 _____

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- b. Is the prescribed drug part of a clinical trial? 上述處方藥物是否屬於臨床試驗？

Yes 是 No 否

If "Yes", please provide the following information. 如「是」，請提供以下資料。

- i. Stage of clinical trial 臨床試驗階段

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- ii. Medical justification for using the experimental drug 使用該試驗藥物的醫療理據

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- iii. Please state and provide supporting evidence, such as relevant medical journal articles, and submit them together with this application. 請註明並提供支持文件，例如相關醫學期刊文章，並與本申請一併遞交。

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I / We hereby declare that the information given on this form is true and complete to the best of my / our knowledge and belief.
本人 / 我們現聲明此申請書上所填資料皆為本人 / 我們所知及所信之事實及其全部。

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Name of Attending Physician / Specialist (with qualifications)
主診 / 專科醫生的姓名 (資歷)

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Signature (with chop) 簽名 (蓋印)

--

Address and Telephone No. 地址及電話

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Date 日期