



# 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。







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**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實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。

<div style="border: 1px solid black; height: 80px; width: 100%;"></div>		<div style="border: 1px solid black; height: 80px; width: 100%;"></div>	
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)		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)	
Name 姓名 <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		Name 姓名 <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
ID Card / Passport Number 身份證 / 護照號碼 <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		Date 日期 <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
ID Card / Passport Number 身份證 / 護照號碼 <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		Date 日期 <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
Relationship with the Insured 與受保人關係 <div style="border: 1px solid black; height: 40px; width: 100%;"></div>		Signature of Witness 見證人簽署 <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>		Name 姓名 <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>		Date 日期 <div style="border: 1px solid black; height: 20px; width: 100%;"></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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- 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？

Yes 是  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 *only in hospital*? 是次檢查 / 手術所需的設備 僅設置於醫院？

Yes 是  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？

Yes, please specify reasons for hospital stay 可以，請說明住院原因

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

- Current health status (co-morbidity) 現時健康狀況（合併）症  
 Expected higher risk at operation 預期手術時存在較高風險  
 Expected higher post-operative risk 預期手術後存在較高風險  
 Others, please specify reasons for admission and hospitalisation  
 其他，請註明必須入院的原因

Please specify 請說明

- e. Is this a case of medical emergency? 這是否醫療緊急個案？

No 否  Yes 是，please specify 請說明

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：

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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

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

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。

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

--

Date 日期