




DISMEMBERMENT CLAIM FORM

斷肢賠償申請表

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	
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	
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	
TR Membership Number 業務代表會員號碼	<input type="checkbox"/> IA	<input type="checkbox"/> ANG	03402126

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 / 保險或理財顧問 / 業務代表資料，您最新生效保單的友邦財務策劃顧問 / 保險或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。

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

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. Are you left-handed? 閣下是否左手慣用者？	5. <input type="checkbox"/> Yes 有 <input type="checkbox"/> No 沒有

PLEASE SIGN & RETURN IMMEDIATELY BUT NO LATER THAN 14 DAYS 請簽署後即時但不遲於14天內遞交

PLEASE DO NOT SIGN ON BLANK FORM 請勿在空白表格上簽署

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ACCIDENT PARTICULARS 意外詳情：

6. a) Date and time of accident 意外日期及時間	6. a) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> <input type="checkbox"/> A.M. 上午 MM月 DD日 YYYY年 HR時 MIN分 <input type="checkbox"/> P.M. 下午
b) Where and how did it happen? 意外地點及經過	b) <input type="text"/>
c) Part of body injured and type of injury 受傷部位及傷勢 (Please provide photo of the injured area for our reference. 請提供受傷部位之相片以供參考。)	c) <input type="text"/>

TREATMENT PARTICULARS 治療詳情：

7. Give details of consultation. 診治詳情		
	Name and Address of Doctor / Hospital 醫生 / 醫院名稱及地址	Consultation Date 求診日期
a) The doctor first consulted for this accident and First Consultation Date 首次就診的醫生資料及日期		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MM月 DD日 YYYY年
b) The doctor you last consulted for this accident and the Last Consultation Date. 最後求診的醫生資料及日期		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MM月 DD日 YYYY年
c) If hospitalized, please state the period of hospitalization. 若曾住院，請列出住院時段。	From 由 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MM月 DD日 YYYY年	To 至 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MM月 DD日 YYYY年
d) The doctor who referred you to hospital. 建議入院的醫生資料。		

RECORD OF MEDICAL CONSULTATION / HOSPITALIZATION 過往之求診及住院紀錄：

8. Details of Physician(s) consulted or hospital(s) admitted for current accident. 因是次意外曾就診之醫生姓名或入住之醫院詳情。		
Name and Address of Doctor / Hospital 醫生 / 醫院名稱及地址	Admission / Consultation No.(s) 住院 / 求診號碼	Admission / Consultation Date(s) 住院 / 求診日期
		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MM月 DD日 YYYY年
		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MM月 DD日 YYYY年
		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MM月 DD日 YYYY年

GENERAL 其他資料：

9. Are you insured for similar disability benefit(s) with any other Company? If "yes", please state. 閣下是否在其他公司投保類似喪失工作能力保障？如“有”，請填寫下欄。 <input type="checkbox"/> Yes 有 <input type="checkbox"/> No 沒有				
Name of Insurer(s) 投保公司名稱	Type / Amount of Benefit(s) 投保類別 / 金額	Amount of Benefit(s) 金額	Rider(s) Attached 附加契約	Policy Number 保單號碼

CLAIMS PAYMENT OPTION 支付賠償方法：**IMPORTANT NOTE 重要事項：**

For customers who have registered Faster Payment System (FPS) to bank accounts in Hong Kong Dollars (HKD), or eBank-in to bank accounts in Hong Kong Dollars (HKD) or Macau Patacas (MOP), claims payment will be remitted to the designated bank account. 如客戶已登記使用「轉數快」並連結至港元銀行戶口，或已登記使用「電子入賬服務」並連結至港元或澳門幣銀行戶口，賠償款項將會自動存入指定銀行戶口。

For customers who have registered eBank-in to bank accounts in United States Dollars (USD), claims payment will be made by cheque in USD by default.

如客戶已登記「電子入賬服務」並連結至美元銀行戶口，賠償款項將預設以美元支票支付。

To receive claims payment easily and conveniently, please register FPS / eBank-in by completing the following:

為更方便快捷收到賠償款項，請填妥以下資料以即時登記「轉數快」或「電子入賬服務」：

Remarks 註：

To allow successful claims payment through FPS / eBank-in, all policies belonged to same owner must be registered for FPS / eBank-in. We will notify you by SMS upon completion of the registration. 保單持有人的所有保單須登記「轉數快」或「電子入賬服務」以允許我們以「轉數快」或「電子入賬服務」支付賠償款項。我們將於完成登記當日發送短訊通知您。

Owner's Mobile Number**持有人流動電話號碼：**

We will update the telephone number to the above policy(ies) accordingly if it is different from the Company record. We will notify you by SMS upon completion of the registration. 如此號碼跟公司紀錄不同，我們會更新有關號碼至以上保單。我們將於完成登記當日發送短訊通知您。

Identity proof must be provided for registration of FPS / eBank-in if you have not submitted a **valid Identity Card / Passport** before. 如未曾提供有效的身份證 / 護照，需遞交身份證明文件作登記「轉數快」或「電子入賬服務」之用。

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AIA INTERNATIONAL LIMITED
友邦保險(國際)有限公司
(hereinafter called "AIA" 以下簡稱 "友邦保險")
DECLARATION AND AUTHORIZATION 聲明及授權

Important Note 注意事項

- (a) In order to speed up your claim application, please attach the required claims documents together with this application form. You may check the required documents on our website (<http://www.aia.com.hk> > Help & Support > Health Care and Claims > How to file a Claim). 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 financial planner / 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.
為使能儘速辦理您的索償申請，請將此表格連同有關索償文件一併遞交。有關申請索償所需遞交之文件，請參閱友邦的網頁 (<http://www.aia.com.hk> > 客戶支援 > 醫療保健和索償 > 如何索償)。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，我們會通知您或友邦財務策劃顧問 / 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。
- (b) In case you want to claim for other benefits, you have to complete an appropriate claim form of that respective claim type and file it in together with the necessary supporting evidence.
如您還需申請其他賠償類別，您須另行填寫及遞交相關的索償申請表格和所需證明。
- (c) Please submit your claim application to our AIA financial planner / your broker / IFA or send it to us at the following address:
請將您的索償申請交予友邦財務策劃顧問 / 您的保險顧問 / 投資顧問，或郵寄至以下地址：
- HK : AIA Customer Service Centre, 12/F AIA Tower, 183 Electric Road, North Point, Hong Kong
香港：友邦客戶服務中心，香港北角電氣道183號友邦廣場12樓
 - Macau : AIA Customer Service Centre, Unit 201, 2F, AIA Tower, Nos. 251A-301, Avenida Comercial de Macau, Macau
澳門：友邦客戶服務中心，澳門商業大馬路251A-301號友邦廣場2樓201室

Levy on Premium 保費徵費**Important Note 重要通知**

The policy owner is required by the Insurance (Levy) Regulation ("the Regulation") to pay to the company the premium along with the prescribed levy which will be remitted to the Insurance Authority ("IA") by the company. Any failure to do so may result in a breach of the Regulation under which the IA may impose on the policy owner concerned a pecuniary penalty not exceeding HK\$5,000 and take legal proceedings to recover any outstanding levy and penalty as a civil debt.

保單持有人須按《保險業（徵費）規例》（“規例”）在繳交保費時向本公司一併繳交法定保費徵費，並由本公司把保費徵費轉付至保險業監管局（“保監局”）。如保單持有人沒有繳付保費徵費，或被視為違反規例，保監局可向該人施加不超過港元5,000元的罰款，而欠付的徵費及罰款可作為欠保監局的民事債項而由該局追討。

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 box on the left, I / We hereby give my / our irrevocable consent to the Company to deduct any outstanding levy, if any, from the claims payment and insurance proceeds if the related policy(ies) will be terminated after this claim. All of the outstanding levy of the policy(ies), if any, will be shared by the Owner / Assignee / Trustee / Beneficiary who gave consent to the Company as of the claims processing date on an equal split basis. I / We also understand and acknowledge that the policy owners' information is required to be provided to the Insurance Authority if the levy is overdue.

本人 / 我們聲明，本人 / 我們為此索償申請書中列明的保單之持有人 / 受讓人 / 信託人 / 受益人（視情況而定）。除非於左列空格劃上「X」號，否則本人 / 我們完全同意如有關保單因是次索償而終止，公司會從賠償金額及保險賠償金中扣除有關保單尚欠的保費徵費（如適用）。於保單索償程序展開時已授權公司作出扣除的保單持有人 / 受讓人 / 信託人 / 受益人將平均承擔保單所有尚欠的保費徵費。本人 / 我們明白及承認如保單持有人過期繳交保費徵費，公司須向保險業監管局提供保單持有人的資料。

PERSONAL DATA COLLECTION AND USE

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.

個人資料收集及使用

我 / 我們確認我 / 我們已閱讀、明白及同意我 / 我們的保單繕發人及 / 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 / 我們的保單繕發人及 / 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 / 退休金計劃在香港繕發）或澳門境外 / 境內（如保單 / 退休金計劃在澳門繕發）（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。

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DECLARATION AND AUTHORIZATION 聲明及授權

I / We DECLARE that the answers given above are true and complete.

本人 / 我們現聲明以上每一項答案為完全和真確。

I / We hereby irrevocably authorize:

本人 / 我們茲授權:

- a. any organization, institution, 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 AIA may disclose any such information. This authorization shall bind my / our / the Insured's successors and assigns and remain valid not with standing 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 / 被保人診治之機構、組織或人士、向友邦保險透露有關資料，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. AIA 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.

友邦保險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。

<div style="border: 1px solid black; height: 50px; width: 100%;"></div> <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書一致)</p>		<div style="border: 1px solid black; height: 50px; width: 100%;"></div> <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書 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: 30px; width: 100%;"></div>		<p>Name 姓名</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
<p>ID Card / Passport Number 身份證 / 護照號碼</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<p>Date 日期</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<p>ID Card / Passport Number 身份證 / 護照號碼</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<p>Date 日期</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
<p>Relationship with the Insured 與受保人關係</p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div>		<p>Signature of Witness 見證人簽署</p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	
		<p>Name 姓名</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<p>Date 日期</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
<p>This declaration and authorization must be signed by the insured. If the insured is a minor, the insured's parent / legal guardian can sign on his/her behalf. 此聲明及授權書必須由受保人簽署，若受保人為小童，則可由其家長 / 合法監護人簽署。</p> <p>Please complete the following information if the signature is not given by the insured. 若簽署者非受保人，請填寫下列資料。</p>			
<div style="border: 1px solid black; height: 60px; width: 100%;"></div> <p>Name of Insured 受保人姓名 (in block letter 正楷書寫)</p>		<div style="border: 1px solid black; height: 60px; width: 100%;"></div> <p>Relationship with the Insured 與受保人關係 (Please provide documentary proof for the relationship. 請提交關係證明文件)</p>	



Download our AIA+ mobile app to manage your policy!
下載 AIA+ 手機應用程式以便輕鬆管理您的保單！

"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)**第二部份由受保人自費由主診醫生或手術醫生填寫****For Loss of Speech / Loss of Hearing 喪失說話能力及 / 或失聰適用**

<p>1. (a) Name of patient 病人姓名 <input type="text"/></p> <p>(b) ID Card / Passport Number 身份證 / 護照號碼 <input type="text"/></p> <p>(c) Occupation 職業 <input type="text"/></p>	<p>4. Please give details of treatment administered (such as suturing, physiotherapy, etc. with treatment dates) 請提供治療詳情 (如縫針、物理治療等) 及治療日期。 <input type="text"/></p>
<p>2. (a) Accident Date 意外日期 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MM月 DD日 YYYY年</p> <p>(b) Please specify part of body injured and type of injury. 請列明受傷部位及其類別。 <input type="text"/></p> <p>(c) Cause of Loss of Speech and / or Loss of Hearing 導致喪失說話能力及 / 或失聰之原因 <input type="text"/></p> <p>(d) Duration of Loss of Speech 喪失說話能力之持續時段 <input type="text"/></p> <p>(e) Was the diagnosis confirmed by an audiometric and sound-threshold test? 診斷是否由合適的耳、鼻、喉專科醫生確認並已進行聽力及聲域測驗? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p>	<p>5. (a) Was there any hospitalization, x-rays and / or special diagnostic procedures required? 此次受傷是否需要住院、X光檢查及 / 或特別診斷程序? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>(b) If yes, please give details. 如是，請提供詳情。</p> <p>(c) Was any surgery rendered? 有沒有進行手術? <input type="checkbox"/> Yes 有 <input type="checkbox"/> No 沒有</p> <p>(d) If yes, please give details (such as name of procedure and date of surgery) 如有，請提供詳情 (如手術名稱及施行手術日期)。 <input type="text"/></p>
<p>3. (a) Present condition of injury 現時受傷情況 <input type="text"/></p> <p>(b) Do you expect a fundamental or marked change of patient's present condition in the future? 閣下認為病者現時之狀況會否有基本 / 明顯的改善? <input type="checkbox"/> Yes 會 <input type="checkbox"/> No 不會</p> <p>(c) Is the loss of Speech and / or Loss of Hearing considered total and irreversible? 喪失說話能力及 / 或失聰之狀況是否屬於完全及永久性之缺陷? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>(d) Please state any further treatment / rehabilitation plan. 請說明任何進一步之治療 / 康復計劃。 <input type="text"/></p>	<p>6. (a) Was the injury induced from or affected by any of the following? 受傷是否由下列情況導致或影響? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p><input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 Physical defects / congenital anomaly 身體缺陷 / 先天性毛病</p> <p><input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 Unfavorable past medical history 過往病史</p> <p><input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 Degenerative changes 退化轉變</p> <p><input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 Alcohol or drugs 酒精或藥物</p> <p>(b) Please give details if any of the above answers is "yes". 如以上任何一項為“是”，請提供詳情。 <input type="text"/></p>
<p>7. Please enclose copies of all reports from (Ear, Nose and Throat) specialists, audiometric and sound-threshold reports, CT Scan, MRI, X-ray, laboratory tests, surgical reports and any relevant hospital reports. 請提供所有報告包括耳、鼻、喉專科醫生之報告、聽力及聲域測驗報告、電腦掃描、磁力共振、X光檢查、化驗報告，或任何有關的醫院報告。</p>	

PERSONAL DATA COLLECTION AND USE

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<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.

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個人資料收集及使用

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 / 或友邦偉峰人壽有限公司 (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。

<input type="text"/> Name of Attending Physician / Specialist (with qualifications) 主診 / 專科醫生的姓名 (資歷) <input type="text"/> Address and Telephone No. 地址及電話	<input type="text"/> Signature (with chop) 簽名 (蓋印) <input type="text"/> Date 日期
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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****For Loss of Sight 喪失視力適用**

1. (a) Name of patient 病人姓名

(b) ID Card / Passport Number 身份證 / 護照號碼

(c) Occupation 職業

2. (a) Accident Date 意外日期

MM	月	DD	日	YYYY	年

(b) Please specify Part of body injured and Type of injury

請列明受傷部位及其類別

(c) Cause of blindness

導致失明之原因

(d) What is the visual acuity of both eyes at present?

雙眼現時之視力分別為多少?

 Left Eye 左眼:

 Right Eye 右眼:

3. (a) What kinds of treatment were rendered?

施行了哪些治療?

(b) Was any surgery rendered?

有沒有進行手術治療?

 Yes 有 No 沒有

(c) If yes, please give details (such as name of procedure and date of surgery)

如有，請提供詳情（如手術名稱及施行手術日期）

4. (a) Was there any hospitalization, x-rays and / or special diagnostic procedures required?

此次受傷是否需要住院、X光檢查及/或特別診斷程序?

 Yes 是 No 否

(b) If yes, please give details.

如是，請提供詳情

5. (a) What is the prognosis?

病情進展如何?

(b) Will further surgery improve the patient's sight?

再次施行手術會否對病者的視力有改進?

 Yes 會 No 不會

(c) If yes, what kind of surgery will be necessary?

如會，病者需要接受什麼手術?

6. (a) Was the injury induced from or affected by any of the following?

受傷是否由下列情況導致或影響?

 Yes 是 No 否 Physical defects / congenital anomaly

身體缺陷 / 先天性毛病

 Yes 是 No 否 Unfavorable past medical history

過往病史

 Yes 是 No 否 Degenerative changes

退化轉變

 Yes 是 No 否 Alcohol or drugs

酒精或藥物

(b) Please give details if any of the above answers is "yes".

如以上任何一項為“是”，請提供詳情。

7. (a) Do you expect a fundamental or marked change of patient's present condition in the future?

閣下認為病者現時之狀況會否有基本 / 明顯的改善?

 Yes 會 No 不會

(b) Please state any further treatment / rehabilitation plan.

請說明任何進一步之治療 / 康復計劃。

8. Please enclose copies of all reports including ophthalmologist reports, CT Scan and any relevant reports that are available.

請提供所有報告包括眼科專家報告、電腦掃描，或任何有關的醫院報告。

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Name of Attending Physician / Specialist (with qualifications)

主診 / 專科醫生的姓名（資歷）

Address and Telephone No.

地址及電話

Signature (with chop)

簽名（蓋印）

Date

日期

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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****For Third Degree Burn 三級燒傷適用**

<p>1. (a) Name of patient 病人姓名 <input type="text"/></p> <p>(b) ID Card / Passport Number 身份證 / 護照號碼 <input type="text"/></p> <p>(c) Occupation 職業 <input type="text"/></p>	<p>5. (a) Was there any hospitalization, x-rays and / or special diagnostic procedures required? 此次受傷是否需要住院、X光檢查及 / 或特別診斷程序? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>(b) If yes, please give details. 如是，請提供詳情。 <input type="text"/></p> <p>(c) Was any surgery rendered? 有沒有進行手術? <input type="checkbox"/> Yes 有 <input type="checkbox"/> No 沒有</p> <p>(d) If yes, please give details (such as name of procedure and date of surgery) 如有，請提供詳情（如手術名稱及施行手術日期） <input type="text"/></p>
<p>2. (a) Accident Date 意外日期 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MM月 DD日 YYYY年</p> <p>(b) Please specify Part of body injured and Type of injury 請列明受傷部位及其類別 <input type="text"/></p> <p>(c) Please use a diagram to specify the part of body injured. 請利用圖表以列明受傷部位。 <input type="text"/></p> <p>(d) What was the cause of major burns? 嚴重燒傷因何引致? <input type="text"/></p> <p>(e) Is the burn considered as Third Degree Burns (full thickness skin destruction)? 燒傷之程度是否屬於第三級燒傷（皮膚全層燒傷）? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>(f) Extent of the burn covering the body surface (in %). 身體表面燒傷之程度（百分比）。 <input type="text"/></p>	<p>6. (a) Was the injury induced from or affected by any of the following? 受傷是否由下列情況導致或影響? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p><input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 Physical defects / congenital anomaly 身體缺陷 / 先天性毛病</p> <p><input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 Unfavorable past medical history 過往病史</p> <p><input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 Degenerative changes 退化轉變</p> <p><input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 Alcohol or drugs 酒精或藥物</p> <p>(b) Please give details if any of the above answers is "yes". 如以上任何一項為“是”，請提供詳情。 <input type="text"/></p>
<p>3. (a) Present condition of injury 現時受傷情況 <input type="text"/></p> <p>(b) Please describe the current physical impairment, if any. 請詳述受保人現時之身體缺陷 / 損害情況(如適用)。 <input type="text"/></p>	<p>7. (a) Do you expect a fundamental or marked change of patient's present condition in the future? 閣下認為病者現時之狀況會否有基本 / 明顯的改善? <input type="checkbox"/> Yes 會 <input type="checkbox"/> No 不會</p> <p>(b) Please state any further treatment / rehabilitation plan. 請說明任何進一步之治療 / 康復計劃。 <input type="text"/></p>
<p>4. Please give details of treatment administered (such as suturing, physiotherapy, etc. with treatment dates) 請提供治療詳情(如縫針、物理治療等)及治療日期。 <input type="text"/></p>	<p>8. Please enclose copies of surgical reports and all relevant hospital reports that are available. 請提供所有手術報告，或任何有關的醫院報告。 <input type="text"/></p>

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<input type="text"/> Name of Attending Physician / Specialist (with qualifications) 主診 / 專科醫生的姓名（資歷） <input type="text"/> Address and Telephone No. 地址及電話	<input type="text"/> Signature (with chop) 簽名（蓋印） <input type="text"/> Date 日期
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PART III (To be completed by the Insured / Claimant) 第三部份 (由受保人 / 索償人填寫)

Note: This part is to be signed by the insured / claimant and applies when the insured is being examined for the said injury by the Company's staff doctor.
 附註: 若是由本公司的醫生負責為受保人或索償人檢驗所述之傷患, 則此部份適用, 並需由受保人填寫及簽署。

STATEMENT BY THE INSURED / CLAIMANT FOR ACCIDENT INDEMNITY
受保人 / 索償人申請意外賠償之聲明

To : AIA International Limited
 致 : 友邦保險(國際) 有限公司

With respect to the examination of the above-mentioned injury conducted by the AIA's staff doctor (hereinafter called "the said doctor") for the purpose of assessing my claim (as opposed to my own attending doctor), I hereby agree and confirm that: 有關由友邦保險的醫生 (以下簡稱「上述醫生」) 負責為本人進行驗傷, 以便評估本人之索償申請的事宜 (而非本人之主診醫生), 本人謹此同意及確認:

- (a) The medical findings by the said doctor shall be relied upon by the AIA when processing my said claim, and 由上述醫生作出之檢驗結果將成為友邦保險處理本人上述索償申請的根據。
- (b) I understand that this examination does not prevent or restrict me from consulting with my own attending doctor at any time in the future for further medical assessments, advice or treatments that may be necessary for the said injury. 本人明白是次檢驗並不會對本人將來任何時候因所述傷患而需向本人之主診醫生尋求進一步的醫療評估及醫治時構成任何限制。

<div data-bbox="119 672 790 840" style="border: 1px solid black; height: 75px;"></div> <p>Signature of Witness 見證人簽署</p>	<div data-bbox="790 672 1484 840" style="border: 1px solid black; height: 75px;"></div> <p>Signature of Insured / Claimant 受保人 / 申請人簽署 (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書一致)</p>
<p>Name 姓名:</p> <div data-bbox="119 952 790 1064" style="border: 1px solid black; height: 50px;"></div>	<p>Name 姓名:</p> <div data-bbox="790 952 1484 1064" style="border: 1px solid black; height: 50px;"></div>
<p>Date 日期:</p> <div data-bbox="119 1198 790 1265" style="border: 1px solid black; height: 30px;"></div>	<p>ID Card / Passport No. 身份證 / 護照號碼;</p> <div data-bbox="790 1108 1484 1176" style="border: 1px solid black; height: 30px;"></div> <p>Date 日期:</p> <div data-bbox="790 1198 1484 1265" style="border: 1px solid black; height: 30px;"></div>