AIA International Limited
(Incorporated in Bermuda
with limited liability)

GROUP ACCIDENT CLAIM FORM
團體意外賠償申請書

PART I-TO BE COMPLETED BY THE INSURED / CLAIMANT
甲部 - 由受保人或申請人填寫

Name of Employer / Group Policyholder: 僱主／團體保單投保公司名稱	Name of Insured Employee / Member: 受保僱員／成員姓名	Age: 年歲
Group Policy No.: 團體保單編號	HK / Macau ID Card No.: 香港／澳門身份証號碼	Sex: 性別
Contact Phone No. (daytime): 日間聯絡電話	E-mail Address: 電郵地址	
This case is a: 本個案為： ☐ New Claim 首次索償 ☐ Further Claim 再度索償		

EMPLOYMENT PARTICULARS:
就業詳情

1. Present occupation (if more than one, state all) and exact nature of occupational duties: 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 medical leave certificate to your employer? 曾否向僱主遞交病假證明書	3. ☐ Yes 有 ☐ No 沒有

ACCIDENT PARTICULARS:
意外詳情

1. Date and time of accident: 發生意外之日期及時間	1. M M D D Y Y 月 月 日 日 年 年 _____ am / pm 上午／下午
2. Where and how did it happen? 發生意外之地點及經過	2.
3. Type of injury and part of body injured 受傷類別，受傷部位及傷勢	3.

TREATMENT PARTICULARS:
治療詳情

1. Details of hospitals confined or physicians consulted for the injury (Please attach discharge note).
   請列出因此次意外受傷而就診之醫生或醫院（請呈交出院證明書）

Name of Physician(s) & / or Hospital(s) 醫生／醫院名稱	Address 地址	Date of consultation(s) & / or period of confinement(s) 就診／住院日期
a.		
b.		
c.		

PART II-CERTIFICATE OF MEDICAL ATTENDANT - TO BE COMPLETED BY THE SURGEON OR ATTENDING PHYSICIAN

乙部 - 必須由主診醫生填寫

No claims can be admitted unless medical certificate from a duly qualified and registered medical practitioner on the form below be furnished at the expense of the insured.

Name of Claimant / Patient 賠償申請人／病人姓名	HKID Card No. 香港身份証號碼：	Age 年歲： Sex 性別：	Accident date 意外日期：

1. (a) Is there any external and visible evidence of injury at your first consultation 於首次診治時有否外部及表面之受傷痕跡	(a) ☐ Yes 有 ☐ No 沒有
(b) If yes, please state type of injury 如有，受傷類別	(b)
(c) State part of body injured 受傷部位	(c)
(d) Describe the cause and extent of injury 受傷原因及程度	(d)

2. Present condition of injury 現時受傷情況：

3. (a) Is there any treatment administered? 有否進行任何治療 (b) If yes, please give details (such as suturing, physiotherapy, type of dressing, etc.) 若有，請提供詳情（如縫針，物理治療，包紮等）	3. (a) ☐ Yes 有 ☐ No 沒有 (b) Date of Treatment 診治日期 Time (am / pm) 時間（上午／下午） Type of Treatment 治療類別
4. (a) Any other physicians who treated insured for the same injury? 有否就此受傷接受其他醫生之診治 (b) If yes, please give details: 若有，請提供詳情（醫生姓名，地址及診治日期）	4. (a) ☐ Yes 有 ☐ No 沒有 Name 姓名 Address 地址 Date of Treatment 診治日期

5. (a) Did injury require hospitalization, x-rays, special diagnostic procedures and / or surgery?
此次受傷是否需要住院，X光檢查，特別診斷程序及／或進行手術

☐ Yes 有 ☐ No 沒有

(b) If yes, please give details 若有，請提供詳情

6. (a) Was the injury induced from or affected by any of the following? 受傷是否受下列情況導致或影響？

Yes 有	No 沒有	
☐	☐	Physical defects / congenital anomally 身體缺陷／先天性異常
☐	☐	Unfavourable past medical history 過往病史
☐	☐	Degenerative changes 退化轉變
☐	☐	Alcohol or drugs 酒精或藥物

(b) If any of the above is "yes", please give details 如以上任何一項為"是"，請提供詳情

7. (a) Was healing complicated? 有否因其它因素而影響痊癒進度 (b) If so, state why & any special treatment given. 若有，請提供原因及施行之任何特別治療	7. (a) ☐ Yes 有 ☐ No 沒有 (b)
8. In view of the patient's occupation as stated overleaf, do you feel that the injuries would have prevented him / her from working? 就病人之職業而論，閣下是否認為此傷勢會令病人完全不能工作？	8. (a) at your first consultation 首次診治 ☐ Yes 有 ☐ No 沒有 (b) at your recent consultation 最近診治 ☐ Yes 有 ☐ No 沒有
9. If absence from work for more than two weeks are necessary, please describe in detail the reasons why you feel the patient could not return to work earlier. 若不能工作兩星期以上，請詳述閣下認為病人不可提早復工之原因	9.

I hereby certify that I have personally examined & treated the insured for the above injury and the facts as given above present my opinion of his / her condition.

Name of Attending Physician / Specialist & Qualifications
主診／專科醫生的姓名及專業資格

Address 地址

Telephone No.電話號碼

Signature and Stamp of Attending Physician / Specialist
主診／專科醫生之印鑑及簽署

Date 日期

DECLARATION AND AUTHORIZATION

聲明及授權

I / We confirm that I / we have read and understood the AIA Personal Information Collection Statement ("AIA PIC"). I / We declare and agree that any personal data and other information relating to me / us or my / our policy(ies) or investments contained in this enrollment form or collected, obtained, compiled or held by AIA by any means from time to time may be collected and utilized in accordance with the AIA PIC. I / We acknowledge and consent to the transfer of my / our personal data outside of Hong Kong (for policies issued in Hong Kong) or Macau (for policies issued in Macau), as the case may be, for the purposes and to the types of transferee as set out in the AIA PIC.

The updated version of AIA PIC is available for download from its website: www.aia.com.hk, and is made available upon request.

I / We also hereby irrevocably authorize:

(i) any organization, institution, or individual that has any record or knowledge of my / the insured(s)'s employment, sick leave records, accident or loss details (of any sorts), health and medical history or any treatment or advice that has been or may hereafter be consulted to disclose to AIA such information. This authorization shall bind my / the insured(s)'s successors and assignees and remain valid notwithstanding my / the insured(s)'s death or incapacity in so far as legally possible. A photocopy of this authorization shall be as valid as the original.

(ii) AIA or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests, to underwrite and evaluate my / the insured(s)'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 immune deficiency syndrome (AIDS), infection by any human immunodeficiency virus (HIV), immune disorder or the presence of medications, drugs, nicotine or their metabolites.

I / We hereby agree with and authorize AIA to deduct the reimbursement of claims payment in the event that I, and / or my dependents, have any shortfall amount, for whatever reason, due to AIA.

本人 / 我們確認本人 / 我們已閱讀及明白 AIA 個人資料收集聲明（「AIA 個人資料收集聲明」）。本人 / 我們聲明及同意在本申請所載或 AIA 不時以任何方法收集所得、編製或持有的任何個人資料及關於本人 / 我們或本人 / 我們的保單或投資的其他資料，可根據 AIA 個人資料收集聲明收集及使用。本人 / 我們知悉及同意就 AIA 個人資料收集聲明所述目的視乎情況轉讓本人 / 我們的個人資料至香港 (如保單在香港繕發) 或澳門 (如保單在澳門繕發) 境外予 AIA 個人資料收集聲明所載的資料承讓人。

AIA 個人資料收集聲明的最新版本可於 AIA 網址下載：www.aia.com.hk，及可向 AIA 索取。

本人 / 我們茲授權：

(i) 任何知悉或擁有本人 / 受保人之工作、病假記錄、意外或損失 (任何類別) 之詳情、健康狀況及病歷或任何治療或諮詢記錄及曾為或將為本人 / 受保人診治之機構、組織或人士，向友邦保險透露有關資料，不得撤回。即使本人 / 受保人死亡或喪失能力，此授權書仍然存有法律效力，而本人 / 受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。

(ii) 友邦保險或任何其認可之驗身醫生或化驗所，替本人 / 受保人進行所需之醫療評估及測試，並對本人 / 受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、肝或腎功能失常、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、尼古丁及其代謝物之含量等化驗。

本人 / 我們同意及授權友邦保險於賠償金額上扣除本人及 / 或本人家屬尚未清還友邦保險之任何欠款。

Signature of Claimant (18 years or over) 賠償申請人（十八歲或以上）簽署	Signature of Insured Employee / Member (see remark) 受保僱員 / 成員簽署（參考註解）	Date Signed 簽署日期

Remark: 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.
註解：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。

Please complete the following information if the signature is not given by the insured. 若簽署者非受保人，請填寫此欄

Name (in block letter) _____
姓名（正楷書寫）

Relationship with Insured: _____
與受保人關係

Notes for filing a claim

1. Part I should be completed by the insured Employee / Member while Part II by Attending Physician.
2. Original bills and receipts for the claimed expenses must be attached showing the date of treatment, patient's name, diagnosis and the Attending Physician's stamp and signature.
3. Claim for medical expenses must be submitted within 90 days from incurring such expenses. Otherwise, the claims will be declined for reimbursement.
4. Please make copies as necessary. Certified true copies of bills and / or receipts will be provided if specified in this form.
5. No benefit is payable for the conditions listed under "LIMITATIONS AND EXCLUSIONS" of the master policy.

申請賠償須知

1. 此表格之甲部由受保僱員 / 成員填寫，而乙部則須由主診醫生填報。
2. 必須附上正本單據及收條，單據及收條須包括診治日期、病者姓名、診斷以及主診醫生蓋章及簽署。
3. 醫療費用賠償應於九十天內申請。否則賠償會被拒絕接受辦理。
4. 請自行影印副本。如清楚註明於本申請書，友邦保險將會提供單據及 / 或收條之核證副本。
5. 如費用源於保單內所列的「限制情況和不保事項」恕不受保。

Remarks : "AIA" refers to AIA International Limited (incorporated in Bermuda with limited liability)
備註：「友邦保險」是指友邦保險 (國際) 有限公司 (於百慕達註冊成立之有限公司)