



**AIA International Limited**  
(Incorporated in Bermuda  
with limited liability)

**GROUP MEDICAL INSURANCE – HOSPITALIZATION & SURGICAL CLAIM FORM**

**團體醫療保險—住院及手術賠償申請表**

(This form is applicable to both inpatient and outpatient surgical claim)  
(本申請表格適用於住院及門診手術賠償)

**PART I – Member Information – TO BE COMPLETED BY THE MEMBER / INSURED EMPLOYEE**  
**甲部—成員資料 (由成員 / 受保僱員填寫)**

* Please complete all the information below, otherwise, it cannot be processed. * 請填寫以下資料, 否則閣下之賠償申請將不能處理	
1. Group Policy No. 團體保單編號 : *	6. HK/Macau ID No. of the Insured Employee 受保僱員香港/澳門身份証 : *
2. Name of Employer / Group Policyholder 僱主 / 團體保單投保公司名稱 : *	7. Claimant Member ID (10 digits no. shown in the medical card) (Compulsory) 賠償申請人成員號碼(醫療卡上顯示的十位數字) (必須填寫) : *
3. Name of Insured Employee / Member 受保僱員 / 成員姓名 : *	**Please complete items 8 to 9 if item 7 cannot be provided **如未能提供第七項之資料, 請填寫第八至九項
4. Name of Claimant / Patient 賠償申請人 / 病者姓名 : *	
5. Relationship to Insured Employee / Member 與受保僱員 / 成員之關係 : *	8. Certificate No. of the Insured Employee 受保證書號碼 : **
<input type="checkbox"/> Self 本人 <input type="checkbox"/> Spouse 配偶 <input type="checkbox"/> Children 子女 <input type="checkbox"/> Others 其他:	9. Employee No. of the Insured Employee 僱員編號 : **
10. Have you / the claimant had any prior treatment for this or related conditions? 閣下 / 賠償申請人是否曾經因同一病況而接受治療? <input type="checkbox"/> No 沒有 <input type="checkbox"/> Yes 有 Doctor's Name 醫生姓名: _____ Date(s)日期: _____ Address 地址: _____	
11. Are you / the claimant making any other insurance claim as a result of this hospitalization / surgery? 有關此次住院 / 手術, 閣下 / 賠償申請人是否有申請其他保險賠償? <input type="checkbox"/> No 沒有 <input type="checkbox"/> Yes 有 Name of Insurance Company 保險公司名稱: _____ Policy No. 保單編號: _____ Type of Compensation 賠償類別: _____	
12. Will you / the claimant also apply for insurance claim under any individual policy(ies) with AIA (where applicable) by this claim if the medical expenses exceed the coverage amount of the Group Policy? 如是次的醫療開支超出團體保單的保障額, 閣下 / 賠償申請人會否同時經此賠償申請向友邦保險的個人保單(如適用)申請保險賠償? <input type="checkbox"/> No 不會 <input type="checkbox"/> Yes 會 If yes, please specify the Policy No. 如會, 請註明保單編號: _____ Agent Code 營業員號碼: _____ If no agent code is specified above, AIA would notify this claim's information to your AIA financial planner / broker / IFA according to the Company's record. If you do not want AIA to inform them of this application, please tick the box <input type="checkbox"/> . 就是次賠償, 若營業員資料一欄中沒有指定跟進之營業員資料, 我們將根據友邦之記錄, 通知您的友邦財務策劃顧問 / 保險顧問 / 投資顧問。如閣下不欲友邦是次申請通知上述顧問, 請在方格內劃上剔號 <input type="checkbox"/> 。	
13. Was the hospitalization / surgery a result of an accident? 此次住院 / 手術是否由於一宗意外引致? <input type="checkbox"/> No 不是 <input type="checkbox"/> Yes 是 Date 日期: _____ Time 時間: _____ Place 地點: _____ Brief Description 經過: _____	

**Declaration and Authorization**

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 claim 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](http://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 the 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.

**聲明及授權**

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(如保單在香港續發)或澳門(如保單在澳門續發)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](http://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, 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 / 受保人之繼承人或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、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 Insured Employee / Member  
受保僱員 / 成員簽署

Signature of Patient (18 years of age or over)  
病者簽署 (十八歲或以上)

Date Signed  
簽署日期

Logon 24-hour AIA Employee Benefits Online Service through [AIA.COM.HK](http://AIA.COM.HK) to check your claim records and / or benefit now!  
請登入 [AIA.COM.HK](http://AIA.COM.HK) 之 24 小時友邦僱員福利網上服務查閱您的賠償紀錄及 / 或福利概要

**Note for filing a claim**

- Part I should be completed by the Insured Employee / Member while Part II by Attending Physician.
- 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. Referral letter must be attached for specialist consultation.
- Claim for hospitalization & surgical expenses are advised to be submitted **WITHIN 90 days** from the date of leaving the hospital / surgery to facilitate earlier claim settlement. (Please note that any claims submitted after 90 days will be denied.)
- Please make copies as necessary. Certified true copies of bills and / or receipts will be provided if specified in this form.
- How to submit the claim form?
  - Fill in the claim form and sign
  - Attach the original claim receipt
  - Send to your Human Resources Department or plan administrator (if applicable)
- You may logon AIA Employee Benefits Online Service through [AIA.COM.HK](http://AIA.COM.HK) to check your processed claim records.
- AIA address in HK: AIA International Limited, Corporate Solutions Department, 12/F, AIA Financial Centre, 712 Prince Edward Road East, Kowloon, Hong Kong  
AIA address in Macau: AIA International Limited, Corporate Solutions Department, 1903, AIA Tower, Nos. 251A-301 Avenida Commercial de Macau, Macau

**申請賠償須知**

- 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。
- 必須附上正本單據及收條，單據及收條須包括診症日期、病者姓名、診斷以及主診醫生蓋章及簽署。
- 專科賠償，必須附上轉介推薦書。
- 為使早日完成賠償，住院 / 手術費用賠償申請，請於出院後 / 手術日起**九十日內**遞交。(請注意：友邦保險不受理診斷日期 / 出院九十日後才提出的賠償申請。)
- 請自行影印副本。如清楚註明於本申請表，友邦保險將會提供單據及 / 或收條之核證副本。
- 如何遞交賠償申請表?
  - 填寫此申請表及簽署
  - 請附上理賠收據正本
  - 交回貴公司人事部或有關負責人(如適用)
- 您可隨時登入 [AIA.COM.HK](http://AIA.COM.HK) 之友邦僱員福利網上服務查閱閣下已被處理的理賠紀錄。
- 友邦香港辦事處：香港九龍太子道東 712 號友邦九龍金融中心 12 樓友邦保險團體業務部  
澳門友邦保險辦事處：澳門商業大馬路 251A-301 號友邦廣場 1903 室友邦保險團體業務部

**PART II – TO BE COMPLETED BY THE SURGEON OR ATTENDING PHYSICIAN****乙部一必須由主診醫生填報**

Patient's Name: \_\_\_\_\_

病者姓名: \_\_\_\_\_

Patient's HK/Macau ID Card No.: \_\_\_\_\_

病者香港 / 澳門身份証編號: \_\_\_\_\_

<p>1. a. What was the period of hospitalization? 住院期間 Admission Date 入院日期 _____ Discharged Date 出院日期 _____</p> <p>b. Place of Services 診症地點 <input type="checkbox"/> Ward 大房 <input type="checkbox"/> Semi-Private 二等房 <input type="checkbox"/> Private 私家房</p>	<p>8. Was the condition caused by or in any way associated with the conditions mentioned below? 病人之病情是否由下列情況所導致或有關連</p> <table border="0"> <thead> <tr> <th>Conditions 情況</th> <th>Yes 是</th> <th>No 否</th> </tr> </thead> <tbody> <tr> <td>a. the influence of drugs or alcohol intake? 藥物或酒精</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>b. AIDS, venereal disease or sexually transmitted disease? 愛滋病, 性病或由性接觸而傳染的疾病</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>c. infertility or sterilization? 不育或節育</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>d. cosmetic or plastic surgery? 美容或整容手術</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>e. mental or nervous disorder? 精神錯亂</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>f. congenital deformities or anomalies? 先天性異常</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>g. suicide, insanity or self-infliction? 自殺, 神智不清或自殘</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>h. correction of eye sight? 視力改正</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>	Conditions 情況	Yes 是	No 否	a. the influence of drugs or alcohol intake? 藥物或酒精	<input type="checkbox"/>	<input type="checkbox"/>	b. AIDS, venereal disease or sexually transmitted disease? 愛滋病, 性病或由性接觸而傳染的疾病	<input type="checkbox"/>	<input type="checkbox"/>	c. infertility or sterilization? 不育或節育	<input type="checkbox"/>	<input type="checkbox"/>	d. cosmetic or plastic surgery? 美容或整容手術	<input type="checkbox"/>	<input type="checkbox"/>	e. mental or nervous disorder? 精神錯亂	<input type="checkbox"/>	<input type="checkbox"/>	f. congenital deformities or anomalies? 先天性異常	<input type="checkbox"/>	<input type="checkbox"/>	g. suicide, insanity or self-infliction? 自殺, 神智不清或自殘	<input type="checkbox"/>	<input type="checkbox"/>	h. correction of eye sight? 視力改正	<input type="checkbox"/>	<input type="checkbox"/>
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<p>2. a. Please give chief complaint / diagnosis for this hospitalization. 此次住院之病情 / 診斷 _____</p> <p>b. Describe the type of treatment / surgical procedure given to the patient. 治療及手術詳情 _____</p>	<p>9. a. Were the treatment(s), the medical test(s) and the length of stay in hospital (if any) directly related to the current diagnosis all medically necessary and recommended by you? 是次檢查、治療及住院日數(如有)是否和上述診斷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 請詳述之 _____</p> <p>Please answer the following questions if the insured requires hospitalization:- 若受保人需要住院,請回答以下問題:</p> <p>b. Can the treatment and the medical test(s) be managed under an out-patient setting instead? 是次檢查及治療可否在門診處理,而無須在醫院進行? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否, please give details 請詳述之 _____</p> <p>If "Yes", why was the patient admitted to hospital? 若可以在門診處理,請說明病人住院的原因。 _____</p>																											
<p>3. When were the symptoms first presented or when did the accident happen? 首次出現病徵的日期或意外發生的日期 _____</p>																												
<p>4. a. When was the first consultation for this treatment / sickness? 首次就此病徵 / 狀況及有關病而就診的日期 _____</p> <p>b. Has the patient received continuous treatment related to this sickness since then? 自首次受診後,病者有否繼續接受同類治療 _____</p>	<p>10.a. Was the hospitalization / treatment medically necessary? 是次入院是否醫療所需 <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是, please give details 請詳述之 _____</p> <p>b. For the average patient, what is the usual duration of hospitalization for this sickness? 一般而言,同類病況之平均住院日數 _____</p> <p>c. Was it possible to provide this treatment on an outpatient basis? 此治療能否在門診進行 <input type="checkbox"/> No 不能 <input type="checkbox"/> Yes 能, please give details 請詳述之 _____</p>																											
<p>5. If such hospitalization was due to accident, please state how it happened. 如是次入院由意外引起,請註明如何發生 _____</p>																												
<p>6. Was the patient referred to you by another doctor? 病人是否經其他醫生轉介 <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是</p> <p>If "Yes", please give name and address of the referring doctor. 若是,請列轉介醫生的姓名及地址 Doctor's Name 醫生的姓名 _____ Address 地址 _____</p>	<p>11. Did any complications arise during such hospitalization? 是次住院有否引起併發症 <input type="checkbox"/> No 沒有 <input type="checkbox"/> Yes 有, please give details 請詳述之 _____</p>																											
<p>7. a. Have you treated the above patient for this or related sickness before? 在這之前,閣下有否就同樣疾病治療病者 <input type="checkbox"/> No 沒有 <input type="checkbox"/> Yes 有, please give details 請詳述之 _____</p> <p>b. Was the condition a recurrent episode or a chronic disease? 此病況是否再次復發或是慢性疾病 <input type="checkbox"/> No 否 <input type="checkbox"/> Yes 是, it was 此病乃 _____</p> <p>the date of first attack was on 第一次發生的日期 _____</p>	<p>12. Did the patient take any home leave during the hospital confinement? 病人有否於住院期間離開醫院? <input type="checkbox"/> No 沒有 <input type="checkbox"/> Yes 有</p> <p>If "Yes", please state the date and time. 若有,請詳述日期及時間 _____</p>																											

Name of Attending Physician &amp; Qualifications 主診醫生的姓名及專業資格

Signature and Stamp of Attending Physician 主診醫生之印鑑及簽名

Address 地址 \_\_\_\_\_

Telephone No. 電話號碼 \_\_\_\_\_

Date 日期 \_\_\_\_\_

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)