AIA International Limited
(Incorporated in Bermuda with limited liability)
Pre-approval Enquiry 预先批核服务查询

Hong Kong 香港 Hotline 热线： CEO plan 至尊医疗计划 (852) 2232 8870
Other medical plan 其他医疗计划 (852) 2232 8888
Fax 传真： (852) 3118 9083

Macau 澳门 Hotline 热线： (853) 8988 1822
Fax 传真： (853) 2831 5900

Simple guide for Medical Expense Pre-approval Service

(Only applicable to AIA designated medical plan)

医疗费用预先批核服务简易指南

（只适用于AIA指定之医疗保障计划）

1

Fill out and return the Pre-approval Form to us
at least 2 - 4 working days prior to admission or day of medical procedure
请填妥预先批核表格，并于入院或接受医疗程序前最少两至四个工作天交回给我们
E-mail for Hong Kong Customers 电邮地址香港客户：**hk.pre-admission@aia.com**
Fax no. for Hong Kong Customers 传真号码香港客户：**(852) 3118 9083**
Fax no. for Macau Customers 传真号码澳门客户：**(853) 2831 5900**

2

Once pre-approval request is completed, you will be informed for the result
预先批核一经完成，我们会通知您有关结果

3

Once "Credit Facility Service" has been successfully set-up, we will send a "Letter of Guarantee" (LOG) to the concerned hospital. Upon registration at hospital, please present insured's identification document for verification and notify hospital that "Letter of Guarantee" has been arranged by AIA
「免找数服务」一经安排，我们会向有关医院发出「付款保证书」。
于医院登记时，请出示受保人之身份证明文件以作核实，并通知医院AIA已为病人发出「付款保证书」

4

The hospital will send us the bills and we will settle the approved medical expense on behalf of you. Upon claim assessment is completed, if the medical expense exceeds the payable amount under eligible benefit, a Shortfall Notification will be sent to Policyowner and the designated credit card will be automatically charged with the shortfall amount 14 days from the date of the notification
完成治疗后，医院会直接向我们递交医疗单据，我们会替您直接缴付有关已获批核的医疗开支。
当理赔程序完成后，如有关医疗开支高于合资格保障应支付的赔偿额，
我们会向您发出「差额付款通知书」，并于发信日十四天后直接从授权的信用卡中扣除。

5

For enquiry, please contact AIA Pre-approval Hotline 如有查询，欢迎致电友邦预先批核服务热线:
For Hong Kong Customers 香港客户：**(852) 2232 8870 (CEO plan** 至尊医疗计划) 或
(852) 2232 8888 (Other medical plan 其他医疗计划)
For Macau Customers 澳门客户：**(853) 8988 1822**
For Mainland China Customers 中国内地客户：**400-8428009**
(IDD function is required to get through the Toll Free Hotline 客户电话须有国际长途功能才能打通免费专线)

Note to take:

i) Pre-approval Service or Credit Facility Service is not a contractual service but an administrative arrangement offered in our absolute discretion in respect of covered expenses incurred. It is subject to termination at any time without prior notice.
医疗费用预先批核服务或「免找数服务」为一项就受保人于治疗期间所衍生的受保开支而设的行政安排，而并非保单保障内容，我们有权随时撤销此项服务而毋须另行通知，并保留绝对决定权。

ii) If treatment or hospitalisation is due to illness/disability classified under exclusion or whatsoever, no LOG will be issued
如因不受保事项而引发之治疗或住院，均不会获发「付款保证书」

iii) You will be required to provide treatment information and authorise AIA to collect any shortfall including any uncovered items, etc. if any, from your authorised credit card account
您须提供治疗资料及授权友邦从您授权的信用卡帐户中收取差额费用包括不受保障项目等（如有）

iv) The actual date of claims notification depends on the submission of required documents by the hospital
赔偿通知的实际日期须视乎医院递交齐备文件所需日数而有所不同

v) All the claims settlement will be subjected to the final bill and the policy terms & conditions
所有赔偿决定受医疗账单及保单条款及细则约束

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MEDICAL EXPENSE PRE-APPROVAL FORM
医疗费用预先批核表格

PART I – TO BE COMPLETED BY INSURED / CLAIMANT 第一部份－由受保人或申请人填写

Please complete this form and return it to us by fax or e-mail at least 2 - 4 working days prior to admission or date of medical procedure.
请填妥此表格并于入院或接受医疗程序前最少两至四个工作天，以传真或电邮方式递交。

Policy Number
保单号码：(如多于一份医疗保单，请填写所有保单编号)

Name of Policy Owner
保单持有人姓名：

Name of Insured (Patient)
受保人（病人）姓名：

Insured (Patient) I.D. Card / Passport Number
受保人（病人）身份证/护照号码：

Contact Telephone No.
联络电话号码：

Contact Telephone No. in U.S.
美国联络电话号码：

E-mail Address / Fax. No.
电邮地址或传真号码：

☐ No 否 **If you do not want AIA to inform your agent about this pre-approval request, please tick "No".**
如阁下不欲友邦就是次预先批核申请，通知有关业务代表，请在"否"加上剔号 。

Area Code
区域编号

Agency / Broker Name
营业员组别 / 经纪名称

Agent / Broker Code
营业员号码 / 经纪号码

Agency Code
营业员组别编号

Agent / TR's Name
营业员 / 经纪姓名

Agent / TR's Tel. No.
营业员 / 经纪联络电话

TR Membership Number 业务代表会员号码 ☐ PIBA ☐ CIB ☐ ANG

Are you making any AIA Group Policy or other insurance or compensation claim as a result of this treatment? ☐ Yes 是 ☐ No 否
有关是次治疗，阁下有否向友邦团体保单或其他保险公司 / 机构申请赔偿?

If "Yes", please provide the following information 如有，请提供下列资料:

Name of AIA Group Policy Employer / Other Insurance Company / Organisation
友邦团体雇主名称 / 其他保险公司/机构名称:

Group Policy No. / Certificate No. / Policy No. / Membership No.
团体保单号码 / 受保证书编号 / 保单 / 会员编号

PLEASE COMPLETE QUESTIONS 1 TO 5 IF HOSPITALISATION IS DUE TO ACCIDENT
因意外受伤入院请填写问题1至 5

1. Date and time of accident 意外日期及时间： MM月 DD日 YYYY年 ☐ A.M. 上午 ☐ P.M. 下午 HR时 MIN分
2. Where and how did the accident happen 意外地点及经过：
3. Part of body injured and type of injury 受伤部位及伤势：
4. Present occupation (if more than one, state all) and exact nature of occupational duties 现职（若有兼职请列明）职位及职责：
5. Name and address of business or employer 公司或雇主名称及地址：

PLEASE COMPLETE QUESTIONS 6 TO 8 IF HOSPITALISATION IS DUE TO ILLNESS 因病入院请填写问题 6至 8

6. Give a brief description of symptoms 描述病征及病状：
7. How long have these symptoms existed prior to the first consultation?
该等病征在首次求诊前已存在多久？
8. Give details of consultations 诊治详情
   a) The doctor first consulted for this illness 首次就诊的医生资料： Date 求诊日期 MM月 DD日 YYYY年
      Name and address of doctor / hospital
      医生 / 医院名称及地址：
   b) The doctor who referred the insured to hospital / other doctors seen for this or similar past condition 建议入院的医生资料 / 其他曾诊治此病或过往同类病况的医生资料： Date 求诊日期 MM月 DD日 YYYY年
      Name and address of doctor / hospital
      医生 / 医院名称及地址：

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Policy Number 保单号码 | | | | | | | | | | |

No Claim Discount (NCD) (Only Applicable to product with NCD) 索偿折扣（只适用于享有无索偿折扣的产品）

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.

若保单持有人获得无索偿折扣并已支付折扣后的保费，及后本公司若须就以往任何保单年度所出现的索偿而作出应付或已付赔偿，本公司会将按照实际的索偿年度及其相应的索偿折扣重新计算实际之合资格的折扣后保费。

Declaration and Authorization 声明及授权

☐ 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 putting a tick ✓ 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 / 我们声明，本人 / 我们为此索偿申请书中列明的保单之持有人 / 受让人 / 信托人 / 受益人（视情况而定）。除非于上列空格划上✓号，否则本人 / 我们完全同意，公司会从保险赔偿金中扣除超出根据实际合资格无索偿折扣所重新计算的保费金额及有关保费徵费（如适用）。

DECLARATION AND AUTHORISATION 声明及授权

PERSONAL DATA COLLECTION AND USE

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 application or collected, obtained, compiled or held by the Company 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.

个人资料收集及使用

本人 / 我们确认本人 / 我们已阅读及明白AIA个人资料收集声明（「AIA个人资料收集声明」）。本人 / 我们声明及同意在本申请所载或贵公司不时以任何方法收集所得、编制或持有的任何个人资料及关于本人 / 我们或本人 / 我们的保单或投资的其他资料，可根据AIA个人资料收集声明收集及使用。本人 / 我们知悉及同意就AIA个人资料收集声明所述目的视乎情况转让本人 / 我们的个人资料至香港（如保单在香港缮发）或澳门（如保单在澳门缮发）境外予AIA个人资料收集声明所载的资料承让人。
AIA个人资料收集声明的最新版本可于以下网址下载：www.aia.com.hk，及可向贵公司索取。

I/We hereby irrevocably authorise:

a. Any organisation, 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 authorised representative of the Company may disclose any such information. This authorisation shall be valid as the original.
b. This 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.
c. Neither submission of this Pre-Approval Form nor the issuance of Letter of Guarantee by the Company shall be construed as admission of liability on the part of the Company.
d. In the event that the Company has settled any charges not covered in the policy or exceeds my / our / the Insured's eligible benefit limit, the Company shall have the right to deduct any of such charges from the credit card as specified below. However, if the Company cannot collect such shortfall due to insufficient credit available in the credit card account or for any other reason whatsoever, the Company shall have the right to setoff the shortfall amounts against the amount due or payable to me / us / the Insured from this Policy and/or any policy issued by the Company of which I / we / the Insured am / are / is the owner(s) or trustee(s) including but not limited to any death benefit (to the extent it is permissible by law), dividends or return of premium (for whatever reason).

本人 / 我们兹授权:

a. 任何知悉或拥有本人 / 我们 / 被保人之工作、病假纪录、意外或损失（任何类别）之详情、健康状况、病历或任何治疗或谘询纪录及曾 / 为或将为本人 / 我们 / 被保人诊治之机构、组织或人士、向贵公司透露有关资料，不得撤回，即使本人 / 我们 / 被保人死亡或丧失能力，此授权书仍然存有法律效力，而本人 / 我们 / 被保人之继承人及转让人亦会受此授权书约束。此授权书之正本与副本同属有效。
b. 贵公司或任何其认可之验身医生或化验所，替本人 / 我们 / 被保人进行所需之医疗评估及测试，并对本人 / 我们 / 被保人之健康状况进行审核及评估，作为处理本申请及其后与之有关的赔偿事宜，不得撤回。此等化验会包括，但并不限于，胆固醇及有关之血脂肪、糖尿病、肾或肝功能失常、爱滋病或感染人体免疫力缺乏病毒、免疫系统失常或体内药物、毒品、尼古丁及其代产品之含量等化验。
c. 递交此次预先批核表格或由贵公司签发出住院付款保证信均不能理解为贵公司承担有关赔偿责任。
d. 若贵公司曾为本人 / 我们 / 受保人支付任何不在受保障范围内的费用，或支付超出有关保障限额的费用时，贵公司将有权从以下指定的信用卡中扣除任何相关的金额。若贵公司因有关信用卡户口的信用额不足，或不论任何其他原因以至未能收取该笔差额，贵公司将有权把应收款项从此保单，及 / 或任何由贵公司签发并以本人 / 我们 / 受保人作为保单持有人或信托人的保单所获支付予本人 / 我们 / 受保人的金额中抵销扣除，包括但不限于任何身故赔偿（法律允许的范围内）、红利或保费退还（不论何种原因）。

Signature of Policy Owner / Trustee 保单持有人 / 信托人签署	Signature of Insured (To be signed by parent / guardian if Insured is below 18 years old) 受保人签署 (若受保人年龄在18岁以下，本申请表格必须由家长签署)
Name of Policy Owner 保单持有人姓名	Name of Insured (Patient) 受保人（病人) 姓名
Policy Owner I.D. Card / Passport Number 保单持有人身份证 / 护照号码	Insured (Patient) I.D. Card / Passport Number 受保人（病人） 身份证 / 护照号码
on 于 MM月 DD日 YYYY年	on 于 MM月 DD日 YYYY年

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PART II – TO BE COMPLETED BY INSURED/CLAIMANT 第二部份－由受保人或申请人填写

Credit Card Authorisation Form for Shortfall Collection 收取差额费用之信用卡授权书

If the amount paid by AIA to the hospital exceeds the eligible claims arising from this hospitalisation, this Form authorises AIA to collect the shortfall amount from the following credit card account. The credit card holder must be the Policy Owner or the insured or with direct relationship between the Policy Owner or the insured e.g. spouse or parent or child (documentary proof of relationship might be required). AIA will hold a minimum of HK$5,000 / MOP5,000 (depends on the estimated shortfall amount) from the credit limit of this credit card account until the claim assessment is fully completed. The shortfall notification will be sent to Policy Owner 14 days prior to the collection.

(Please note only Visa or MasterCard issued by bank in Hong Kong / Macau is accepted. For Hong Kong customer, CCB (Asia) UnionPay Dual Currency Credit Card is accepted.)

如友邦直接向医院支付的费用超出是次住院就合资格保障应支付的赔偿额，此授权书将授权友邦从以下信用卡户口收取有关差额。信用卡持卡人必须为此保单之保单持有人或受保人，或与保单持有人或受保人有直接关系，如配偶或父母或子女（或需提交关系证明文件）。友邦将于信用卡保留港币5,000元 / 澳门币5,000元或以上的信用额(视乎预计差额之金额而定)，直至整个理赔程序完结为止。友邦将于收取差额费用十四天前发出差额付款通知书通知保单持有人有关差额详情。

(请注意，我们只接受由香港/澳门银行发出之VISA或万事达卡。香港客户，我们亦接受中国建设银行(亚洲)银联双币信用卡。)

Credit Card Authorisation Form 信用卡付款授权书 (this section must be completed 此部份必须填写)

Cardholder's Name
持卡人姓名：

Cardholder ID Card / Passport Number
持卡人身份证 / 护照号码:
XXXX

Relationship with the Insured / Policy Owner:
与受保人 / 保单持有人关系：
☐ Insured / Policy Owner
受保人 / 保单持有人
☐ Insured / Policy Owner's
受保人 / 保单持有人之
(Please specify 请注明)
_____
_____

Credit Card Account No.
信用卡号码：
| | | | | - | | | | | - | | | | | - | | | | |

Credit Card Expiry Date
信用卡到期日：

I hereby authorise and direct AIA to debit the outstanding shortfall due from my credit card account
本人授权及指示友邦从本人信用卡户口扣除到期之差额费用

Cardholder's Signature
持卡人签署：

on 于 | | MM月 | | | DD日 | | | | | YYYY年

Contact no. 联络号码：

Policy Number 保单号码 | | | | | | | | | | |

PART III－TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SURGEON AT THE CLAIMANT OWN EXPENSES
第三部份－申请人自费由主诊医生 / 手术医生填写

Name of Patient 病人姓名：

ID Card / Passport Number of patient
病人之身份证 / 护照号码：

Sex 性别：
☐ Male 男
☐ Female 女

Hospital Name 医院名称：

(If confine in hospital in Mainland China, please provide full address. 如入住中国内地医院，请提供详细地址)

Expected Date of Admission / Treatment
预计入院 / 治疗日期：
MM月 DD日 YYYY年

Ward Type 住房类别：
☐ Outpatient 门诊 ☐ Day Care 日间护理病房
☐ Standard 普通病房 ☐ Semi-private 半私家病房
☐ Private 私家病房
☐ Other, please specify 其他，请注明 _____

Expected Length of Confinement (number of days)
预计住院日数：

Medical Condition 医疗详情

1. Chief complaints of the patient relating to this hospitalization / surgery
此次住院 / 手术的主要原因：

2. Onset date of the symptoms / condition
发病日期：
MM月 DD日 YYYY年

3. To the best of your knowledge, has the patient ever had the same or similar conditions or symptoms relating thereto? 据阁下所知，病人以前有没有患有同类病况？ ☐ No 没有 ☐ Yes 有
If Yes, please state dates and details. 如有，请说明何时及当时情况。

Treatment Date 诊治日期：
MM月 DD日 YYYY年

Details 详情：

4. Is illness / injury related to the following condition 此疾病 / 受伤是否由以下情况引起:
a) Congenital anomaly 先天性异常 ☐ Yes 是 ☐ No 否
b) Psychiatric condition 精神病 ☐ Yes 是 ☐ No 否
c) Influence of alcohol, drug or intoxicant 酒精药物或麻醉剂影响 ☐ Yes 是 ☐ No 否
d) Obesity, weight control 肥胖，体重控制 ☐ Yes 是 ☐ No 否
e) Pregnancy, childbirth, abortion 怀孕，分娩，流产 ☐ Yes 是 ☐ No 否

若是，请详述。 If yes, please describe the details.

5. a) Medical / Surgical Procedure required 建议之医疗 / 手术程序：

b) Type of Anaesthesia 麻醉类别：
☐ General 全身麻醉 ☐ Local 局部麻醉 ☐ Monitored anaesthesia care 监护麻醉管理
(For surgery under Monitored Anaesthesia Care, please specify the reason for hospital stay.
如手术在监察麻醉下进行，请注明住院原因。)

6. Please list out any laboratory test(s) / imaging test(s) / other diagnostic investigations required for this hospitalisation and reasons for the same. 建议之化验 / 影像检查 / 其他诊断性检查及接受该等检查的原因。

7. Please list out the medication to be used during this confinement. 请详列是次住院所用之药物。

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8. Estimated Fee 预计费用：

Daily Ward Round Fee 医生每天巡房费 $ _____
(If more than one doctor, please provide the breakdown and justification. 如多于一位医生，请列出明细及原因。)

Surgeon's Fee 外科手术费 $ _____
(If more than one surgical procedure, please provide the breakdown. 如多于一项手术程序，请列出明细。)

Anaesthetist's Fee 麻醉师费 $ _____

Operating Theatre Charges 手术室费 $ _____

Operating Appliances, Equipment, Material, etc. Fee 手术用具、仪器及物料等费用 $ _____

Other Hospital Charges 其他医院费用 $ _____

Total Estimated Fee 预计总费用 $ _____

9. a) Are the treatment(s), the medical test(s) and the length of stay in hospital (if any) directly related to current diagnosis, and are medically necessary and recommended by you? ☐ Yes 是 ☐ No 否
是次检查、治疗及住院日数（如有）是否和上述诊断有直接关系而且是医疗所需及由医生建议?
If No, please give details. 若否，请详述之。

Please answer the following questions if the insured requires hospitalization 若受保人需要住院，请回答以下问题：

b) Are the medical test(s) and equipment available only in hospital? 该检查所需的设备是否仅在医院可有? ☐ Yes 是 ☐ No 否
If No, please specify the reason for hospital stay. 若否，请注明住院原因。

c) Are the equipment for the surgical procedure available only in hospital? 该手术所需的设备是否仅在医院可有? ☐ Yes 是 ☐ No 否
If No, please specify the reason for hospital stay. 若否，请注明住院原因。

d) Can the medical test(s) and the procedure be done on an outpatient basis / at day surgery centre? ☐ Can 可以 ☐ Cannot 不可以
该检查及手术可否在门诊 / 日间手术中心进行?
If Yes, please specify the reason for hospital stay 若可以，请说明病人住院的原因。

If No, please give details. 若不可以，请详述之。

e) Please indicate the clinical risk(s) and medical reason(s) for hospitalization: 请注明临床风险及须留院的医疗原因：

☐ Current Health Status (Co-morbidity) 现时健康状况（合并症）：
Please specify 请明确说明：

☐ Expected higher risk at operation 预期较高手术风险：
Please specify 请明确说明：

☐ Expected higher post-operative risk 预期较高手术后风险：
Please specify 请明确说明：

☐ Others, please specify the reason for admission and hospitalization.
其他，请注明必须入院及留院的原因：

f) Is it a case of emergency? 这是否紧急个案？ ☐ Yes 是 ☐ No 否
If yes, please specify. 如是，请明确说明。

I / We hereby declare that the information given on this form is true to the best of my / our knowledge and belief.
本人 / 我们现声明此申请书上所填资料皆为本人 / 我们所知及所信之事实。

Doctor's name 医生姓名：		Signature of Doctor and Chop 医生签署及印章：	
Contact no. 联络号码：			
Fax no. 传真号码：		Date 日期：	MM月 DD日 YYYY年

PA 042020