AIA International Limited
(Incorporated in Bermuda with limited liability)

Pre-Admission Enquiry預先入院登記查詢

	Hong Kong 香港	Macau 澳門
Hotline 熱線:	(852) 2232 8870	(853) 8988 1822
Fax傳真:	(852) 3118 9083	(853) 2831 5900

Pre-Admission — 5 Simple Steps
(Only applicable to AIA designated hospital plan)
Your One-stop Hassel-free Service for Complete Peace of Mind During Your Hospital Stay

入院簡單五步驟
（只適用於AIA指定醫療保障計劃）
一站式簡易申請出院免找數服務，令您入住醫院變得安心又放心

1

Please contact AIA Pre-Admission Hotline 請致電友邦預先入院登記查詢熱線:
For Hong Kong Customers 香港客戶: (852) 2232 8870
For Macau Customers 澳門客戶: (853) 8988 1822

2

Fill out and return the Pre-Admission Form to us at least 2 - 4 working days prior to admission
請填妥入院前登記表格並於入院前最少兩至四個工作天交回給我們
Fax no. for Hong Kong Customers 傳真號碼香港客戶: (852) 3118 9083
E-mail for Hong Kong Customers 電郵地址香港客戶: hk.pre-admission@aia.com
Fax no. for Macau Customers 傳真號碼澳門客戶: (853) 2831 5900

3

Once "Credit Facility Service for Hospitalisation" has been successfully set-up, we will inform you the arrangement details by phone and will send a "Letter of Guarantee" (LOG) to the concerned hospital
「出院免找數服務」一經安排，我們會聯絡您有關細節。我們會向有關醫院發出「住院付款保證書」

4

Upon admission, present the insured's identification document to the hospital for verification
入院時，請向醫院提交受保人之身份證明文件以作核實

5

On discharge, the hospital will send the invoice directly to us. Once our Claims Department completes the case assessment, if there is any shortfall, a shortfall notification will be sent to you 14 days prior to the collection
出院後，醫院會將單據直接遞交我們，當賠償部完成評估後，如有差額，「差額付款通知書」將於收取差額費用十四天前發出

Note to take:

i) Final decision of LOG issuance is subject to the discretion of AIA
友邦保留發出「住院付款保證書」最終決定安排

ii) If hospitalisation is due to illness/disability classified under exclusion or whatsoever, no LOG will be issued
如因不受保事項而引發入住醫院, 均不會獲發「住院付款保證書」

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
您須提供治療資料及授權友邦從您授權的信用卡帳戶中收取差額費用包括不受保障項目等（如有）

iv) The actual date of claims notification depends on the submission of required documents by the hospital
賠償通知的實際日期需視乎醫院遞交齊備文件所需日數而有所不同

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"We", "us", "our", "AIA" or the "Company" herein refers to AIA International Limited (Incorporated in Bermuda with limited liability).
「我們」、「AIA」、「公司」或是指友邦保險（國際）有限公司（於百慕達註冊成立之有限公司）

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INDIVIDUAL HOSPITALISATION PRE-ADMISSION FORM 入院前登記表格

PART I — TO BE COMPLETED BY POLICY OWNER/INSURED 第一部分 — 由保單持有人或受保人填寫

Please complete this form and return it to us by fax or e-mail at least 2 - 4 working days prior to admission to hospital. Subject to the eligibility of the Insured (Patient) a "Letter of Guarantee" will be issued by AIA.

請填妥此表格並於入院前最少兩至四個工作天，以傳真或電郵方式遞交。於受保人（病人）符合資格情況下，友邦將為受保人簽發「住院付款保證信」。

Policy Number 保單號碼**:**	**Name of Policy Owner** 保單持有人姓名**:**
Name of Insured (Patient) 受保人(病人)姓名**:**	**Insured (Patient) I.D. Card/Passport Number** 受保人(病人身份證)／護照號碼
Contact Telephone No. 聯絡電話號碼**:**	**E-mail Address/Fax. No.** 電郵地址和傳真號碼**:**
Contact Telephone No. in U.S. 美國聯絡電話號碼**:**	

No 否 **If you do not want AIA to inform your agent about this hospitalisation Letter of Guarantee application, please tick "No".**
如閣下不欲友邦就是次住院付款保證信的申請, 通知有關業務代表，請在"否"加上剔號 。

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**	**TR Membership Number 業務代表會員號碼** ☐ PIBA ☐ CIB ☐ ANG
Agency Code 營業員組別編號	**Agent / TR's Name 營業員 / 經紀姓名**	**Agent / TR's Tel. No. 營業員 / 經紀聯絡電話**	☐☐☐☐☐☐☐☐☐☐

Are you making any AIA Group Policy or other insurance or compensation claim as a result of this treatment?
有關是次治療，閣下有否向友邦團體保單或其他保險公司/機構申請賠償? ☐ **Yes** 是 ☐ **No**否

If "Yes", please provide the following information 如有，請提供下列資料**:**

Name of AIA Group Policy Employer/Other Insurance Company/ Organisation 友邦團體僱主名稱/其他保險公司/機構名稱:

Group Policy No./Certificate No./Policy No./Membership No. 團體保單號碼/受保證書編號/保單/會員編號**:**

PLEASE COMPLETE QUESTIONS 1 TO 5 IF HOSPITALISATION WAS DUE TO ACCIDENT 因意外受傷入院請填寫問題 1至 5

1. Date and time of accident 意外日期及時間**:** **MM**月**/DD**日**/YYYY**年 **A.M.** 上午 **P.M.** 下午**:** **HR** 時 **MIN** 分

2. Where and how did the accident happen 意外地點及經過**:**

3. Part of body injured and type of injury 受傷部位及傷勢**:**

4. Present occupation (if more than one, state all) and exact nature of occupational duties 現職（若有兼職請列明）職位及職責**:**

5. Name and address of business or employer 公司或僱主名稱及地址**:**

PLEASE COMPLETE QUESTIONS 6 TO 8 IF HOSPITALISATION WAS DUE TO ILLNESS 因病入院請填寫問題 6至 8

6. Give a brief description of symptoms 描述病徵及病狀**:**

7. How long have these symptoms existed prior to the first consultation? 該等病徵在首次求診前已存在多久?

8. Give details of consultations 診治詳情

(a) The doctor first consulted for this illness 首次就診的醫生資料**: Date** 求診日期**:** MM月/DD日/YYYY年

(b) Name and address of clinic/hospital 醫生/醫院名稱及地址**:**

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Declaration and Authorisation 聲明及授權

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 utilised 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.

個人資料收集及使用

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貴公司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以下網址下載：www.aia.com.hk，及可向貴公司索取。

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 hospitalisation Pre-Admission 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/我們茲授權：

a. 任何知悉或擁有本人/我們/被保人之工作、病假記錄、意外或損失（任何類別）之詳情、健康狀況、病歷或任何治療或諮詢記錄及曾/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. 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. 遞交此次入院前登記表格或由貴公司簽發出住院付款保證信均不能理解為貴公司承擔有關賠償責任。

d. 若貴公司曾為本人/我們/受保人支付任何不在受保障範圍內的費用，或支付超出有關保障限額的費用時，貴公司將有權從以下指定的信用卡中扣除任何相關的金額。若貴公司因有關信用卡戶口的信用額不足, 或不論任何其他原因以至未能收取該筆差額，貴公司將有權把應收款項從此保單，及/或任何由貴公司簽發並以本人/我們/受保人作爲保單持有人或信托人的保單所獲支付予本人/我們/受保人的金額中抵銷扣除, 包括但不限於任何身故賠償(法律允許的範圍內)、紅利或保費退還(不論何種原因)。

Signature of the Policy Owner / Trustee 保單持有人 / 信託人簽署**:**	**Signature of the Insured** (parent/guardian if Insured is below 18 years old) 受保人簽署 （若受保人年齡在18歲以下, 本申請表格必須由家長簽署）**:**	**Date (MM/DD/YYYY)** 日期 （月/日/年）**:**
Policy Owner I.D. Card/Passport Number 保單持有人身份證／護照號碼**:**	**Insured (Patient) I.D. Card/Passport Number** 受保人(病人)身份證／護照號碼**:**	

Part II — TO BE COMPLETED BY INSURED/CLAIMANT 第二部分 — 由受保人或申請人填寫

Credit Card Authorisation Form for Shortfall Collection 收取差額費用之信用卡授權書

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 and the insured e.g. spouse and parent. 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 that for Hong Kong Customers, Visa Card, Master Card and CCB (Asia) UnionPay Dual Currency Credit Card are accepted)

如友邦直接向醫院支付的費用超出是次住院就合資格保障應支付的賠償額，此授權書將授權友邦從以下信用卡戶口收取有關差額。信用卡持卡人必須為此保單之保單持有人或受保人，或與保單持有人及受保人有直接關係，如配偶及父母。友邦將於信用卡保留港幣5,000元 / 澳門幣5,000元或以上的信用額(視乎預計差額之金額而定)，直至整個理賠程序完結為止。友邦將於收取差額費用十四天前發出差額付款通知書通知保單持有人有關差額詳情。
(請注意，香港客戶我們會接受 VISA, MASTER 及建設(亞洲)銀聯雙幣信用卡)

Credit Card Authorisation Form 信用卡付款授權書 (this section must be completed 此部分必須填寫)

Cardholder's Name 持卡人姓名:	Cardholder ID Card / Passport Number 持卡人身份證 / 護照號碼: XXXX	Relationship with the Insured / Policy Owner: 與受保人 / 保單持有人關係:
Credit Card Account No. 信用卡號碼:	Credit Card Expiry Date 信用卡到期日: (MM月/YYYY年)	
I hereby authorise and direct AIA to debit the outstanding shortfall due from my credit card account 本人授權及指示友邦從本人信用卡戶口扣除到期之差額費用		
Cardholder's Signature 持卡人簽署: Date (MM/DD/YYYY) 日期(月/日/年):		Contact no. 聯絡號碼:

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Part III — TO BE COMPLETED BY THE INSURED'S ATTENDING PHYSICIAN/SURGEON AT THE POLICY OWNER/INSURED'S EXPENSES IF ANY
第三部分—由受保人之主診醫生/外科醫生填寫(如有需要，保單持有人/受保人需自行承擔填寫表格費用)

Name of Patient 病人姓名:	**Sex** 性別: □ **Male** 男 □ **Female** 女
Hospital name 醫院名稱:	**Room Class:** □ **Ward** □ **Semi-private** □ **Private** 住 房 級 別: □ 普通病房 □ 半私家 □ 私家
Expected Date of Admission (MM/DD/YYYY) 預計入院日期(月/日/年) :	□ **Day Care** 日間病房 □ **OPD** 門診
Expected Length of Confinement (number of days) 預計住院日數:	

Medical Condition 醫療詳情

1. Diagnosis and associated signs and symptoms 診斷和相關病徵:

2. Onset date of the symptoms/condition 發病日期: _____/_____/_____ **(MM/DD/YYYY** 月/日/年)

3. Is the condition recurrent/chronic?
此情況是否為復發性/慢性?
□ **Yes** 是 □ **No**否

If "Yes", onset date of the first episode:
如"是"，首次發病日為
_____/_____/_____ **(MM/DD/YYYY)**
(月/日/年)

4(a) Were the treatment(s), the medical test(s) and the length of stay in hospital (if any) directly related to 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?
□ **Yes** 是 □ **No** 不是
If No, please give details. 若不是, 請詳述之。

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:

4(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?
□ **Yes** 可以 □ **No** 不可以
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。

If "No", please give details. 若不可以在門診處理, 請詳述之。

5. Is illness/injury related to the following condition 此疾病 / 受傷是否由以下情況引起:

a) Congenital anomaly 先天性異常	□ **Yes** 是	□ **No** 否
b) Psychiatric condition 精神病	□ **Yes** 是	□ **No** 否
c) Influence of alcohol, drug or intoxicant 酒精藥物或麻醉劑影響	□ **Yes** 是	□ **No** 否
d) Obesity, weight control 肥胖, 體重控制	□ **Yes** 是	□ **No** 否
e) Pregnancy, childbirth, abortion 懷孕，分娩，流產	□ **Yes** 是	□ **No** 否

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Treatment Details 治療詳情

6. Medical / Surgical Procedure required 建議之醫療/手術程序

Are the equipment(s) for the procedure available only in hospital? If "No", please give details.
該手術所需的設備是否僅在醫院可有? 若不可以，請詳述之。

Can the procedure be done on an outpatient basis? If "No", please give details.
該手術可否在門診進行? 若不可以，請詳述之。

Estimated Surgeon Fee charges 預計外科手術費:

Estimated Ward Round Fee 預計巡房費:

Anaesthesia 麻醉:	**Estimated Anaesthesia fee charges 預計麻醉費:**
☐ **General 全身麻醉**	
☐ **Local 局部麻醉**	
☐ **Monitored anaesthesia care 監護麻醉管理** (For surgery under Monitored Anaesthesia Care, please specify the reason for hospital stay. 如手術在監察麻醉下進行, 請註明住院原因。) _____	

7. Please list out any Lab tests / Imaging / other diagnostic investigations required for this hospitalisation and reasons for the same.
建議之化驗/影像檢查/其他診斷性檢查及接受該等檢查的原因。

Are the investigations available only in hospital? If "No", please give details.
該等檢查是否僅在醫院可有? 若不可以, 請詳述之。

Can the medical test(s) and the procedure be done on an outpatient basis/at day surgery centre?
該檢查及手術可否在門診 / 日間手術中心進行?

Estimated Hospital Expenses Charges 預計醫院費用:

8. Please list out the medication to be used during this confinement if applicable. 請詳列是次住院所用之藥物，如適用。

9. Estimated total fee for this confinement 預計是次住院總費用：

10. Please indicate the clinical risk(s) and medical reason(s) for hospitalization: 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):**
Please specify: 請明確說明: _____

☐ **Expected higher risk at operation: 預期較高手術風險:**
Please specify: 請明確說明: _____

☐ **Expected higher post-operative risk: 預期較高手術後風險:**
Please specify: 請明確說明: _____

☐ **Others, please specify the reason for admission and hospitalization: 其他，請註明必須入院及留院的原因:**
_____

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Treatment Details 治療詳情

11. Is it a case of emergency? 這是否緊急個案?

☐ Yes 是 ☐ No 否

If yes, please specify. 如是，請明確說明。

_____

Doctor's Information 醫生資料

Doctor's name 醫生姓名:	**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。** **Signature of Doctor and Chop 醫生簽署及印章:**
Contact no. 聯絡號碼:	
Fax no. 傳真號碼:	**Date 日期:** **(MM/DD/YYYY 月/日/年)**

Footnote: "We", "us", "our", "AIA" or the "Company" herein refers to AIA International Limited (Incorporated in Bermuda with limited liability).
備註:「我們」、「AIA」、「本公司」或是指友邦保險（國際）有限公司（於百慕達註冊成立之有限公司）。

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