AIA International Limited
(Incorporated in Bermuda
with limited liability)
General Agent 總代理

疾 病 及 意 外 索 償 申 請 表

保單編號 :	C	8	8							

業務代表組別/區域編號 _____ 業務代表姓名/編號 _____

保險顧問/投資顧問名稱/編號 _____ 聯絡電話號碼 _____

請注意，保戶/受保成員應聯同主診醫生正確詳細填妥此申請表，連同正式的費用賬單或收據及主診醫生之處方正本交回本公司賠償部（本公司或會要求進一步資料及文件）。每份申請表只限一位申請人（即病者）填寫。

索 償 資 料 、 聲 明 及 授 權（任何索償申請，均須填妥此部份）

保戶姓名：_____ 身份證號碼：_____ 保單/證書號碼：_____

聯絡地址：_____

索償者姓名：_____ 身份證號碼：_____ 與保戶關係：_____

聯絡電話：_____ 職業：_____

申請賠償之收據數目：_____ 索償總額：_____

友邦保險（國際）有限公司
友邦保險有限公司

聲明及授權

本人/我們現聲明以上每一項答案為完全和真確及確認是次向友邦保險（國際）有限公司（以下簡稱“友邦保險”）遞交之單據乃由本人/我們之醫生發出，單據所載之醫療費用經已全數繳付。

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. 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。

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轉讓本人/我們的個人資料至香港境外予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。

_____ _____

見証人簽署 受保人/申請人簽署（請勿在空白表格上簽署）

姓名: 姓名: 身份證號碼:

日期: 日期:

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。

若簽署者非受保人，請填寫這欄

_____ _____

姓名（正楷書寫） 與受保人關係

Policy Number 保單號碼 | C | 8 | 8 | | | | | | | |

意 外 傷 亡 索 償 （ 申請意外傷亡賠償者須填妥此部份 ）

意外發生日期及時間：_____ 意外發生地點：_____

意外詳情：_____

_____

證人姓名及聯絡地址/電話：_____

（ 以下各項，必須由首位主診醫生填寫 ）

主診醫生姓名及地址：_____

受傷性質：_____

首次接受治療日期：_____ 最後一次接受治療日期：_____

根據閣下意見，是次受傷是否由上述意外引起？_____ 如否，請說明受傷原因：_____

_____

主診醫生簽署：_____ 日期：_____

住 院 索 償 （ 如因意外或疾病而入住醫院，須由主診醫生填寫此部份 ）

主診醫生姓名及地址：_____

傷病者姓名：_____

入院日期：_____ 出院日期：_____

閣下首次診治此症日期：_____

傷病者於閣下第一次診治時提供何種病徵及該病徵持續多久？_____

_____

根據閣下之意見，該病徵存在多久？_____

閣下診斷此傷病者所患何病？_____

以上疾病是否屬於先天性或遺傳性質？_____

若曾動手術，請說明是何種手術：_____

主診醫生簽署：_____ 日期：_____

AIA International Limited
(Incorporated in Bermuda
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General Agent 總代理

Accident & Health Claim Form

Policy No.:	C	8	8							

Agency Name/Area Code _____ Representative Name/Code _____

Broker/IFA Name/Code _____ Contact Phone No. _____

This form must be completed as truthfully and accurately by the Insured or Insured Member with the attending physician and return to our Claims Department together with the official original bills/receipts and attending Physician's prescription/recommendation (Further information/documents may be requested). Separate forms must be used for different claimants (patients).

DETAILS OF CLAIM, DECLARATION & AUTHORIZATION (To be completed for all types of claims)

Insured name: _____ ID card No: _____ Policy/Certificate No: _____

Contact Address: _____

Claimant name: _____ ID card No: _____ Relationship with Insured: _____

Contact No: _____ Occupation: _____

No of receipts submitted: _____ Total claim amount: _____

AIA INTERNATIONAL LIMITED
AIA COMPANY LIMITED

DECLARATION AND AUTHORIZATION

I/We DECLARE that the answers given above are true and complete and I/we have already paid in full to the attending physicians for the medical expenses specified on the receipts which I/We am/are now submitting to AIA International Limited (hereinafter called "AIA").

I/We hereby irrevocably authorize:

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 notwithstanding 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.

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.

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 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.

Signature of Witness
Name:
Date:

Signature of Insured/Claimant (Please do not sign on blank form)
Name: ID No.:
Date:

Remarks: 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.

Please complete if the signature is not given by the insured.

Name (in block letter)

Relationship with the Insured

Policy Number 保單號碼 | C | 8 | 8 | | | | | | | |

ACCIDENT (To be completed for Accident Claims only)

Date & Time of accident: _____ Place of accident: _____

Description how the accident occurred: _____

_____

Witness name & contact address/telephone (If any): _____

(The following must be completed by the first attending Physician)

Name and address of attending Physician: _____

Nature of injuries: _____

Date of first treatment: _____ Date of last treatment: _____

In your opinion, was the injury resulted from the aforementioned accident? _____ If No, please give the cause of injury:

_____

Attending Physician's signature: _____ Date: _____

HOSPITALIZATION (To be completed by the first attending Physician at Insured's own expense, if any, when hospitalized)

Name and address of attending Physician: _____

Name of Patient: _____

Date admitted: _____ Date discharged: _____

Date of your first treatment of the patient for this illness: _____

What symptoms and how long of the symptoms were complained during your first treatment for this illness? _____

_____

In your opinion, how long of the above symptoms had existed? _____

What was your diagnosis of this illness? _____

Was the condition congenital or heredity? _____

If surgical operation was involved, please give type of the operation: _____

Attending Physician's signature: _____ Date: _____