



Network Surgery / Medical Claim Form

網絡手術 / 醫療賠償申請書

PART I (TO BE COMPLETED BY INSURED / CLAIMANT) 第一部份 (由受保人或申請人填寫)

Policy Number 保單號碼	Name of Insured 受保人姓名	ID Card Number / Passport Number 身份證號碼 / 護照號碼
<input type="text"/>	<input type="text"/>	<input type="text" value="XXXX"/>
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
<input type="text"/>	<input type="text"/>	<input type="text"/>
Agency Code 營業員組別編號	Agent / TR's Name 營業員 / 業務代表姓名	Agent / TR's Tel. No. 營業員 / 業務代表聯絡電話
<input type="text"/>	<input type="text"/>	<input type="text"/>
TR Membership Number 業務代表會員號碼	<input type="checkbox"/> IA <input type="text"/>	<input type="checkbox"/> ANG <input type="text"/>



O1002166

Benefits to Claim 索償類別

- Accident Medical Reimbursement 意外醫療費用賠償
 Medical Reimbursement 醫療費用賠償
 Accident / Weekly Indemnity 意外 / 每週賠償
 Hospital Income / Benefit 住院入息 / 惠益
 Maternity Benefit 分娩惠益
 Voluntary Group Assurance 自選團體保障

Remarks: Please take the appropriate box; otherwise we will apply this claim to all of your eligible benefits.

註: 請選擇適用者, 否則我們將會把是次索償申請應用於您的所有同類保障。

EXPRESS CLAIMS SERVICE 特快理賠服務

Please mark a "X" in the box if you request to have your claim be processed by "Express Claims Service" which provides payment for medical claim which requires investigation. You hereby acknowledge that certain terms and conditions (as amended from time to time) shall apply in choosing the "Express Claims Service" and agree to be bound by all the undertakings imposed on you by accepting the payment; you also understand that AIA has not waived any of its rights in the Policy by making the claim payment to you. For details of the Terms and Conditions, please visit AIA Customer Corner at www.aia.com.hk.

- 如欲就此索償申請「特快理賠服務」, 請於空格內劃上「X」號。此服務為需進行調查的醫療申請先作出賠償安排。您於此表示清楚明白某些條款及細則(如不時修訂的)將適用於此「特快理賠服務」, 並同意由接受賠償金起接受有關約束; 亦明白友邦保險並沒有因為是次賠償放棄於保單內的任何權利。有關條款及細則, 請登入www.aia.com.hk之友邦客戶專頁。

Have you received claim payment from AIA group insurance or other insurance for this treatments / receipts submitted? No 沒有 Yes 有
您就是次治療 / 醫療收據是否已獲取友邦團體保險或其他保險賠償?

If yes, please provide the below information and submit relevant insurance company / organization's settlement advice.
如是, 請提供下列資料及遞交有關保險公司 / 機構的賠償金額通知書。

Name of insurance company / organization: 保險公司 / 機構名稱:

Policy No. / Membership No.: 保單 / 會員編號:

If the insured or the policyholder is holding both AIA International Limited and AIA Everest Life Company Limited policies, the claims (including registration of FPS / e-BankIn services) will be processed together. In addition, the "Declaration and Authorization" and "Personal Information Collection and Use" in the claim form will be also applicable to AIA International Limited and AIA Everest Life Company Limited.

若受保人或保單持有人同時持有友邦保險(國際)有限公司及友邦雋峰人壽有限公司之保單, 相關賠償(包括登記「轉數快」或「電子入賬服務」)將會一併處理。此外, 賠償表格內之「聲明及授權」及「個人資料收集及使用」亦同時適用於友邦保險(國際)有限公司及友邦雋峰人壽有限公司。

- If you do not agree on the above arrangement, please mark a "X" in the box. 如果您不同意上述安排, 請於空格內劃上「X」號。

For proper follow up on your claims progress, your AIA financial planner / broker / IFA of your latest inforce policy can view this claim's information if no specific agent / broker / IFA / TR information is provided at above. 為了妥善地跟進您的賠償進度, 若於以上沒有提供指定營業員 / 保險或理財顧問 / 業務代表資料, 您最新生效保單的友邦財務策劃顧問 / 保險或理財顧問將能夠查閱是次申請資料。

- If you do not agree on the above arrangement, please mark a "X" in the box. 如果您不同意上述安排, 請於空格內劃上「X」號。

PLEASE COMPLETE QUESTIONS 1 TO 5 AND 8 TO 10 IF HOSPITALIZATION WAS DUE TO ACCIDENT

因意外受傷入院請填寫問題1至5及8至10

1. Date and time of accident 意外日期及時間
- | | | | | | | | |
|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------------------|----------------------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> A.M. 上午 | <input type="checkbox"/> P.M. 下午 |
| MM月 | DD日 | YYYY年 | HR時 | MIN分 | | | |

2. Where and how did it 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 10 IF HOSPITALIZATION WAS DUE TO ILLNESS 因病人院請填寫問題6至10

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

Name and address of doctor / hospital 醫生 / 醫院名稱及地址

(b) The doctor who referred the insured to hospital / other doctors seen for this or similar past condition 建議入院的醫生資料 / 其他曾診治此病或過往同類病況的醫生資料

Date 求診日期
MM月 DD日 YYYY年

Name and address of doctor / hospital 醫生 / 醫院名稱及地址

9. (a) Please give the date of admission and the date of discharge. 請提供入院及出院日期。

Date of Admission 入院日期
MM月 DD日 YYYY年 Date of Discharge 出院日期
MM月 DD日 YYYY年

(b) Please give the admission period in Intensive Care Unit, if any: 請提供入住深切治療部日期，如適用：

From 由 To 至
MM月 DD日 YYYY年 MM月 DD日 YYYY年(c) Have you taken any home leave during the hospital confinement? No 沒有 Yes 有

您有否於住院期間請假外出？

If Yes, please state the date and time of your home leave.

如有，請列明外出之日期及時間。

10. Any relationship between the Registered Medical Practitioner / Medical Services Provider and Insured / Claimant / AIA Financial Planner / Broker? If so, please state the relationship.

若就診之註冊醫生 / 醫療服務提供者與受保人 / 索償人 / 友邦財務策劃顧問 / 保險經紀有任何關係，請列明之：

CLAIMS PAYMENT OPTION 支付賠償方法：**IMPORTANT NOTE 重要事項：****For customers who have registered FPS / e-BankIn, the payment will be remitted to the designated bank account.****如客戶已登記使用「轉數快」或「電子入賬服務」，賠償款項將會自動入賬至指定銀行戶口****To receive claims payment easily and conveniently, please register FPS / e-BankIn by completing the following:****為更方便快捷收到賠償款項，請填妥以下資料以即時登記「轉數快」或「電子入賬服務」：****Remarks 註：**

To allow successful claims payment through FPS / e-BankIn, all policies belonged to same owner must be registered for FPS / e-BankIn. We will notify you by SMS upon completion of the registration. 保單持有人的所有保單須登記「轉數快」或「電子入賬服務」以允許我們以「轉數快」或「電子入賬服務」支付賠償款項。我們將於完成登記當日發送短訊通知您。

Owner's Mobile Number**持有人流動電話號碼：** _____

We will update the telephone number to the above policy(ies) accordingly if it is different from the Company record. We will notify you by SMS upon completion of the registration. 如此號碼跟公司紀錄不同，我們會更新有關號碼至以上保單。我們將於完成登記當日發送短訊通知您。

Identity proof must be provided for registration of FPS / e-BankIn if you have not submitted a **valid Identity Card / Passport** before. 如未曾提供**有效的身份證 / 護照**，需遞交身份證明文件作登記「轉數快」或「電子入賬服務」之用。

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PERSONAL DATA COLLECTION AND USE 個人資料收集及使用

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.

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。

Signature of Owner / Trustee 持有人 / 信託人簽署 (Please do not sign on blank form and use the signature on our file. 請勿在空白表格上簽署，並確保簽名與保單申請書一致)		Signature of Insured, if other than Owner / Trustee 受保人簽署， 倘非持有人 / 信託人 (Please do not sign on blank form and use the signature on our file. 請勿在空白表格上簽署，並確保簽名與保單申請書 一致) (Whose age is 18 or above 年齡十八歲或以上必須簽署)	
Name 姓名		Name 姓名	
ID Card/Passport Number 身份證 / 護照號碼	Date 日期	ID Card / Passport Number 身份證 / 護照號碼	Date 日期
Relationship with the Insured 與受保人關係		Signature of Witness 見證人簽署	
		Name 姓名	Date 日期

PART II TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SURGEON AT THE CLAIMANT'S OWN EXPENSES
第二部份申請人自費由主診醫生 / 手術醫生填寫

1. (a) Name of patient 病人姓名 <input style="width: 700px; height: 25px;" type="text"/>			
(b) ID Card / Passport Number 身份證 / 護照號碼 <input style="width: 300px; height: 25px;" type="text"/>		(c) Age 年齡 <input style="width: 60px; height: 25px;" type="text"/>	(d) Sex 性別 <input style="width: 60px; height: 25px;" type="text"/>
2. Hospitalization 住院 Name of hospital 醫院名稱: <input style="width: 650px; height: 25px;" type="text"/>			
Date of Admission 入院日期		Date of Discharge 出院日期	
<input style="width: 40px; height: 25px;" type="text"/> <input style="width: 40px; height: 25px;" type="text"/> <input style="width: 80px; height: 25px;" type="text"/>	<input style="width: 40px; height: 25px;" type="text"/> <input style="width: 40px; height: 25px;" type="text"/> <input style="width: 80px; height: 25px;" type="text"/>	<input style="width: 40px; height: 25px;" type="text"/> <input style="width: 40px; height: 25px;" type="text"/> <input style="width: 80px; height: 25px;" type="text"/>	<input style="width: 40px; height: 25px;" type="text"/> <input style="width: 40px; height: 25px;" type="text"/> <input style="width: 80px; height: 25px;" type="text"/>
MM月 DD日 YYYY年		MM月 DD日 YYYY年	
Period in Intensive Care Unit 入住深切治療部日期		To 至	
From 由	<input style="width: 40px; height: 25px;" type="text"/> <input style="width: 40px; height: 25px;" type="text"/> <input style="width: 80px; height: 25px;" type="text"/>	<input style="width: 40px; height: 25px;" type="text"/> <input style="width: 40px; height: 25px;" type="text"/> <input style="width: 80px; height: 25px;" type="text"/>	<input style="width: 40px; height: 25px;" type="text"/> <input style="width: 40px; height: 25px;" type="text"/> <input style="width: 80px; height: 25px;" type="text"/>
MM月 DD日 YYYY年		MM月 DD日 YYYY年	
3. Chief complaints of the patient relating to this hospitalization / surgery 此次住院 / 手術的主要原因 <input style="width: 820px; height: 30px;" type="text"/>			
4. Date of the accident occurred or symptoms first appeared 首次出現病徵日期或意外發生日期		<input style="width: 40px; height: 25px;" type="text"/> <input style="width: 40px; height: 25px;" type="text"/> <input style="width: 80px; height: 25px;" type="text"/>	<input style="width: 40px; height: 25px;" type="text"/> <input style="width: 40px; height: 25px;" type="text"/> <input style="width: 80px; height: 25px;" type="text"/>
		MM月 DD日 YYYY年	MM月 DD日 YYYY年
5. Date of first consultation for this condition or related illness 病人首次求診日期		<input style="width: 40px; height: 25px;" type="text"/> <input style="width: 40px; height: 25px;" type="text"/> <input style="width: 80px; height: 25px;" type="text"/>	<input style="width: 40px; height: 25px;" type="text"/> <input style="width: 40px; height: 25px;" type="text"/> <input style="width: 80px; height: 25px;" type="text"/>
		MM月 DD日 YYYY年	MM月 DD日 YYYY年
6. Final diagnosis / Pathological diagnosis 最終診斷 / 病理診斷		ICD-10 code 國際疾病分類代碼(ICD-10)	
<input style="width: 550px; height: 30px;" type="text"/>		<input style="width: 250px; height: 30px;" type="text"/>	
7. Medical / Surgical Procedure 醫療 / 手術程序		Date of Operation 手術日期	
Nature of Procedure 手術名稱		<input style="width: 40px; height: 25px;" type="text"/> <input style="width: 40px; height: 25px;" type="text"/> <input style="width: 80px; height: 25px;" type="text"/>	<input style="width: 40px; height: 25px;" type="text"/> <input style="width: 40px; height: 25px;" type="text"/> <input style="width: 80px; height: 25px;" type="text"/>
<input style="width: 550px; height: 30px;" type="text"/>		MM月 DD日 YYYY年	
		CPT code 目前使用醫療服務術語代碼	
<input style="width: 550px; height: 30px;" type="text"/>		<input style="width: 250px; height: 30px;" type="text"/>	
8. Present Prognosis 現時進展 <input style="width: 820px; height: 30px;" type="text"/>			
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, and were 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 If No, please give details. 若不是, 請詳述之。 <input style="width: 800px; height: 30px;" type="text"/>			
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:			
(b) Were the medical test(s) and equipment for the procedure available only in hospital? 該檢查及手術所需的設備是否僅在醫院可有?		<input type="checkbox"/> Yes 是	<input type="checkbox"/> No 否
(c) 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?		<input type="checkbox"/> Can 可以	<input type="checkbox"/> Cannot 不可以
(d) The surgery could only be performed under general anaesthesia? 手術是否必須在全身麻醉下進行?		<input type="checkbox"/> Yes 是	<input type="checkbox"/> No 否
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。 <input style="width: 800px; height: 30px;" type="text"/>			
(e) 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:			
<input type="checkbox"/> Current Health Status (Co-morbidity) 現時健康狀況(合併症): Please specify 請明確說明: <input style="width: 780px; height: 30px;" type="text"/>			
<input type="checkbox"/> Expected higher risk at operation 預期較高手術風險: Please specify 請明確說明: <input style="width: 780px; height: 30px;" type="text"/>			
<input type="checkbox"/> Expected higher post-operative risk 預期較高手術後風險: Please specify 請明確說明: <input style="width: 780px; height: 30px;" type="text"/>			
<input type="checkbox"/> Others, please specify the reason for admission and hospitalization: 其他, 請註明必須入院及留院的原因: <input style="width: 780px; height: 30px;" type="text"/>			
(f) Is it a case of emergency? 這是否緊急個案? If Yes, please specify. 如是, 請明確說明。		<input type="checkbox"/> Yes 是	<input type="checkbox"/> No 否
<input style="width: 800px; height: 30px;" type="text"/>			

10. Brief discharge summary (including treatments, investigation procedures, results and / or any complications and follow up plan)
出院摘要：(治療及以後治療計劃，包括診查辦法、結果，併發症及跟進計劃)

11. To the best of your knowledge, has the patient ever had the same or similar conditions or symptoms relating thereto?

據閣下所知，病人以前有沒有患有同類病況？

No 沒有 Yes 有

If Yes, please state dates and details. 如有，請說明何時及當時情況。

Treatment Dates

診治日期

MM月

DD日

YYYY年

Details

詳情

12. Had the patient taken any home leave during the hospital confinement?

病人有沒有於住院期間請假外出？

No 沒有 Yes 有

If Yes, please state date, time and reason of the patient's home leave. 如有，請列明外出之日期、時間及原因。

13. Was the patient referred by another doctor?

病人是不是經其他醫生轉介？

No 不是 Yes 是

Name and address of the referral doctor 轉介醫生的姓名和地址：

14. If the patient is suffering from cancer, please complete the below information.

病人患上癌症，請填寫以下資料：

Yes 有 No 沒有

(a) Treatment details of the patient is: 病人的治療詳情為：

Radiotherapy 放射性治療 Name / Frequency 放射性名稱次數: _____

Chemotherapy 化學治療 Name / Frequency 藥物名稱 / 次數: _____

Targeted Therapy 標靶藥物治療 Name / Details 藥物名稱 / 詳情: _____

Immunotherapy 免疫治療 Name / Frequency 藥物名稱 / 次數: _____

Others 其他 _____

(b) Any Cancer Genomics test done by the patient? 病人有否接受癌症基因檢測？

ACT Genomics 行動基因

FoundationOne 全方位癌症基因檢測

Others 其他 _____

PLEASE COMPLETE IF HOSPITALIZATION WAS DUE TO ACCIDENT 因意外受傷入院請填寫此欄

15. (a) Present Condition of Injury 現時受傷情況：

(b) Patient's occupation and exact nature of occupational duties 病人之職業及職責：

(c) Bearing in mind the patient's occupation, in what way do you feel the injuries would / would not totally prevent the patient from working?
以病人之職業而論，閣下認為此傷勢會不會令病人完全不能工作？請列明原因。

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。

Name of Attending Physician / Specialist (with qualifications)
主診 / 專科醫生的姓名 (資歷)

Signature (with chop) 簽名 (蓋印)

Address and Telephone No. 地址及電話

Date 日期



Download our mobile app AIA Connect to manage your policy anytime, anywhere!
下載AIA「友聯繫」手機應用程式以便輕鬆管理您的保單！

“AIA” shall refer to AIA International Limited (Incorporated in Bermuda with limited liability), AIA Company Limited (Incorporated in Hong Kong with limited liability), as the case may be, depending on the issuing company of the relevant insurance policies this form is subject to. 「AIA」或「友邦」指友邦保險(國際)有限公司(於百慕達註冊成立之有限公司)，友邦保險有限公司(於香港註冊成立之有限公司)(視情況而定)，具體取決於此信件相關表格的簽發公司。