



# Network Surgery / Medical Claim Form

## 网络手术 / 医疗赔偿申请表



If claim application can be done through AIA+ mobile app, there is no need to complete the PART I of this claim form. Please contact your attending doctor to complete PART II of this claim form.

若透过 AIA+ 手机程式递交申请索偿，无需填写此赔偿申请表的第一部分。阁下可进一步安排主诊医生填写赔偿申请表第二部分。

### PART I (TO BE COMPLETED BY INSURED / CLAIMANT) 第一部分 (由受保人或申请人填写)

Policy Number 保单号码	Name of Insured 受保人姓名	ID Card Number / Passport Number 身份证号码 / 护照号码
<input type="text"/>	<input type="text"/>	<input type="text" value="XXXX"/>

Please indicate who to follow up this claim 请指示由以下哪位人士跟进此索偿申请

- By Servicing Agent as policy record 保单记录中的营业员  
 By other agent / broker of below details 其他营业员 / 经纪业务代表资料如下

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
<input type="text"/>	<input type="text"/>	<input type="text"/>

Agency Code 营业员组别编号	Agent / TR's Name 营业员 / 业务代表姓名	Agent / TR's Tel. No. 营业员 / 业务代表联络电话
<input type="text"/>	<input type="text"/>	<input type="text"/>

TR Membership Number 业务代表会员号码  IA   ANG

- By own self of policyowner 保单持有人亲自跟进

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. 为了妥善地跟进您的赔偿进度，若于以上没有提供指定营业员 / 保险或理财顾问 / 业务代表资料，您最新生效保单的友邦财务策划顾问 / 保险或理财顾问将能够查阅是次申请资料。

- 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，请于空格内划上「X」号。

#### Benefits to Claim 索偿类别

- Accident Medical Reimbursement 意外医疗费用赔偿  Medical Reimbursement 医疗费用赔偿  
 Accident / Weekly Indemnity 意外 / 每周赔偿  Hospital Income / Benefit 住院入息 / 惠益  
 Broken Bone 骨折惠益  Voluntary Group Assurance 自选团体保障

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

注：请选择适用者，否则我们将会把申请应用于您的所有同类保障。

#### CLAIMS SEQUENCE 理赔次序

Please use 1, 2, and 3 to indicate the order of claim 请以 1, 2, 3 表示你所选择的理赔顺序

<input type="text" value=""/> AIA Individual Life 友邦个人寿险	<input type="text" value=""/> AIA Group Insurance 友邦团体医疗保险	<input type="text" value=""/> Other Insurance Company 其他保险公司
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Please further provide the below information and relevant settlement advice, if applicable:

请提供以下资料及递交有关的赔偿金额通知书（如适用）：

- (I) AIA Group insurance policy: 1) group policy no. & employer name, 2) member/certificate no., 3) employee name & 4) relationship with employee)

友邦团体医疗保险保单：1) 团体保单号码 & 雇主名称、2) 会员 / 证书编号、3) 员工姓名 & 4) 与员工的关系

- (II) Other insurance company: 1) name of other insurance company, 2) policy no., 3) name of insured & 4) name of policyowner  
其他保险公司：1) 其他保险公司名称、2) 保单号码、3) 受保人姓名 & 4) 人保单持有人名称

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.

若受保人或保单持有人同时持有友邦保险(国际)有限公司及友邦隼峰人寿有限公司之保单，相关赔偿（包括登记「转数快」或「电子入账服务」）将会一并处理。此外，赔偿表格内之「声明及授权」及「个人资料收集及使用」亦同时适用于友邦保险(国际)有限公司及友邦隼峰人寿有限公司。

- 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，请于空格内划上「X」号。

**NETWORK SURGERY / HOSPITALIZATION PARTICULARS 网络手术 / 入院详情**

Please provide the below information 请提供以下资料：

(I) Symptoms, Symptoms onset date or Accident incurred date and cause, diagnosis, name of doctor 徵状、徵状开始或意外发生日期及原因、诊断、医生姓名

(II) Hospitalization / Surgery 手术 / 入院资料

For the illness mentioned above, please provide the name of the hospital where treatment was received, the dates of admission and discharge, and the name of the surgery. 对于上述提到的疾病，请提供接受治疗的医院名称，入院和出院的日期，以及手术的名称。

(III) Besides service provider/patient, please elaborate if insured has other relationship with the attending doctor e.g. immediate family, employer / employee, business partners or insurance agent/broker. 除医生与病人关系外，请说明受保人与医生的其他关系，例如：直系亲属、雇主或雇员、商业合夥人或本公司保险代理人 / 受保人的保险代表。

**CLAIMS PAYMENT OPTION 支付赔偿方法：**

**IMPORTANT NOTE 重要事项：**

For customers who have registered FPS / e-BankIn, the payment will be remitted to the designated bank account. 如客户已登记使用「转数快」或「电子入账服务」，赔偿款项将会自动入账至指定银行账户

To receive claims payment easily and conveniently, please register FPS / e-BankIn by completing the following: 为更方便快捷收到赔偿款项，请填写以下资料以即时登记「转数快」或「电子入账服务」：

**Owner's Mobile Number**

**持有人流动电话号码：** \_\_\_\_\_

If the telephone number provided differs from our company records, we will update it to all or selected policies as indicated in the following section. You will receive an SMS notification upon the completion of the registration.

如所提供的电话号码与公司的纪录不同，我们将根据您于以下部分提供的指示，将该号码更新至您于公司持有的所有或指定的保单。完成登记后，您将收到短讯通知。

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证 / 护照，需递交身份证明文件作登记「转数快」或「电子入账服务」之用

**Complete this section if applying for Hong Kong Policy(ies) 请填写以下部分如申请涉及香港保单：**

- Apply to all your Hong Kong policies held with our Company. 是次申请应用于您于公司所持有之所有香港保单。
- Apply to the following Hong Kong policy / policies. 是次申请只应用于下列之香港保单：

Please select the appropriate box; otherwise we will apply to all of your Hong Kong policies held with our Company. 请选择适用者，否则我们将会把是次申请应用于您于公司所持有之所有香港保单。

Use "FPS / e-BankIn" to transfer policy benefits paid under the above policy to the below designated bank account. The transferred amount will not exceed the maximum limit set by the Company. 使用「转数快」或「电子入账服务」将以上保单号码所支付的保单利益转入下列指定之银行账户，转入之金额将不超过公司所定的上限。

Please select transferring policy benefits paid to **either FPS or e-BankIn**. 请选择「**转数快**」或「**电子入账服务**」其中一项以转入以上保单号码所支付之保单利益。

**a. FPS\* 转数快\*** (Applicable to HKD payment only 只适用于港币付款)

Please select **either ONE** of the "Proxy ID"# below by marking a "X" on appropriate box and provide relevant information. **More than one selection** will be treated as **invalid** application. Your FPS account must also be registered under the policy owner. 请以「X」号选择下列**其中一种**「识别代号」\*及提供以下相关资料。

Email 电邮地址： \_\_\_\_\_

FPS Identifier 「转数快」识别号码： \_\_\_\_\_

Mobile Number 手机号码： \_\_\_\_\_


Country Code                      Telephone No  
国际电话区号                      手机号码

\* **"FPS Service"** means the services provided by us to you from time to time to facilitate payments and funds transfer using the Faster Payment System and related systems and services from time to time provided by Hong Kong Interbank Clearing Limited, together with its successors and assigns.

**「快速支付系统服务(转数快)」**指我们不时向您提供的服务，以让我们使用由香港银行同业结算有限公司及其继承人及受让人不时提供的快速支付系统及相关系统及服务。

# **"Proxy ID"** means an identifier which may be accepted by HKICL for the registration of an account in the HKICL Addressing Service, including your mobile phone number, email address or FPS Identifier.

**「识别代号」**指结算公司接纳用作结算公司账户绑定服务账户登记的识别资料，包括您的手机号码、电邮地址或「转数快」识别号码。

**b. e-BankIn 电子入账服务**

Please provide bank account information below and submit together with the following documents 请提供以下银行账户资料及提交下列之文件：

- 1) Copy of any recent bank passbook / bank correspondence / bank statement (including e-statement) / valid bank card showing the account holder's name and account number. 任何列有户主姓名及银行账户号码最近期的银行存摺 / 信件 / 月结单 (包括电子结单) / 有效银行卡副本。
- 2) Joint account is not allowed. 不接受联名户口。
- 3) e-BankIn account must also be registered under the policy owner. 电子入账服务的户口必须同样为保单持有人。
- 4) Please ensure the bank account holder name is the same as the policyowner name, otherwise the payment will be rejected by banks. 请确保银行账户持有人姓名与保单持有人姓名一致，否则入账指示将不被银行接纳。

Bank Name and Branch in Hong Kong 香港银行及分支之名称

Bank No. 银行编号	Branch No. 分行编号	My Account No. 本人之账户号码

Name as recorded on Bank Passbook / Correspondence / Statement / Bank card (must be same as the Owner of the above Policy)

银行存摺 / 信件 / 月结单 / 银行卡上所记录之户主姓名 (必须与上述保单持有人相同)




**AIA E-ADVISE 「友邦电子通知书」**

(Please mark a "X" in the box to apply for this service. 阁下如欲申请此服务请于空格内划上「X」号。)

Apply for Internet Service "AIA e-Advice" to view / download the softcopies via AIA+ for the above policy and any other policy numbers if specified as below, subject to the "Terms and Conditions for use of AIA+" which is available at <https://www.aia.com.hk/aia-plus/en/tnc>.

申请「友邦电子通知书」网上服务，就以上保单及其他下列保单号码（如有）透过AIA+ 阅览或下载副本，并受「AIA+ 使用条款及细则」之约束，有关条款及细则可于 <https://www.aia.com.hk/aia-plus/zh-hk/tnc>。

\* Email address

电邮地址:

Signature of Owner

持有人签署:

Other policy number(s)

其他保单号码:

(Not applicable to Personal Lines policies with policy prefix C.

不适用于保单号码字首为C之个人财物保险保单。)

**No Claim Discount (NCD) (Only Applicable to product with NCD)****无索偿折扣（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，本公司将会按照实际的无索偿年度及其相应的无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 marking a "X" 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/我们为此索偿申请表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「X」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）。

**PERSONAL DATA COLLECTION AND USE 个人资料收集及使用**

I / We confirm that I / we have read, understood and agreed to the Personal Information Collection Statement(s) of my / our policy issuer(s) and / or pension scheme provider(s), i.e. AIA International Limited (Hong Kong Branch), AIA International Limited (Macau Branch), AIA Company Limited and/or AIA Everest Life Company Limited, where applicable, (the "PICS") which is available for download: <https://www.aia.com.hk/en/privacy-statement-main>.

I / We declare and agree that any personal data and other information relating to me / us or my / our policy(ies), account(s) or investments contained in this application or collected, obtained, compiled or held by my / our policy issuer(s) and / or pension scheme provider(s) by any means from time to time may be collected and utilized in accordance with the PICS.

I / We acknowledge and consent to the transfer of my / our personal data to parties within or outside Hong Kong (for policy(ies) / pension scheme(s) issued in Hong Kong) or Macau (for policy(ies) / pension scheme(s) issued in Macau), as the case may be, for the purposes as set out in the PICS.

The latest version of the PICS which complies with the relevant rules and regulations is / are available for download from the above website and upon request.

我 / 我们确认我 / 我们已阅读、明白及同意我 / 我们的保单缮发人及 / 或退休金计画服务提供者（即友邦(国际)有限公司（香港分行）、友邦(国际)有限公司（澳门分行）、友邦保险有限公司及 / 或友邦隼峰人寿有限公司（如适用））的个人资料收集声明（「此声明」），该声明可在以下网址下载

<https://www.aia.com.hk/zh-cn/privacy-statement-main>。

我 / 我们声明及同意在本申请所载或我 / 我们的保单发人及 / 或退休金计划服务提供者不时以任何方法收集、获得、编制或持有的任何个人资料及关于我 / 我们的保单、帐户或投资的其他资料，可根据该声明收集及使用。

我 / 我们知悉及同意就该声明所述目的转移我 / 我们的个人资料至香港境外 / 境内（如保单 / 退休金计划在海外 / 境内（如保单 / 退休金计划在澳门缮发）（视乎情况而定）予该声明所载的资料承让人。

该声明的符合相关守则及法规之最新版本可于以上网址下载及可供索取。

**DECLARATION AND AUTHORIZATION 声明及授权**

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 "Company").  
 本人 / 我们现声明以上每一项答案为完全和正确及确认是次向友邦保险(国际)有限公司 (以下简称「公司」) 递交之单据乃由本人 / 我们之医生发出, 单据所载之医疗费用经已全数缴付。

I / We hereby irrevocably authorize:

本人 / 我们兹授权:

(a) any organization, institution including but not limited to any hospitals / clinics under The Hospital Authority, 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 the Company 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.

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 / 被保人诊治之任何机构、组织包括但不限于任何医院管理局辖下医院 / 诊所或人士、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) The 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.

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、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) All personal information obtained herein is collected for the purpose of, (i) assessing, processing, evaluating and determining your requests of application for medical claims or services referral and (ii) analysing, investigating, approving and / or determining your claims submitted and will be transferred to AIA's authorized medical panels or its relevant associates / nominees / subsidiaries ("third party administrators"). You authorize us to transfer your personal information to the third party administrators and further give your consent to all third party administrators who / which are in receipt of your personal information that they may process your personal information and transfer all your processed personal information to us for the administration of your insurance policy and provide insurance services to you. Without your voluntary consent, personal information collected will not be transferred to the third party administrators. You can choose not to provide the personal information required, but that will result in not qualifying for receiving any of the services above.

所收集的个人资料会被用作 (i) 评估、处理、审核及厘定您的索偿申请或服务转介及 (ii) 分析、调查、批核及 / 或厘定您的索偿申请之用及转移至友邦保险授权之医疗网络或其相关之附属成员 / 代名人 / 附属公司 (「第三方管理人」)。您授权我们转移您的个人资料给予第三方管理人, 并进一步授权所有第三方管理人在收到您的个人资料后, 他们可以处理您的个人资料并将您的个人资料转移至友邦保险作处理保单行政事宜, 并为您提供保险服务。然而所收集的个人资料未经您授权将不会转移至该第三方管理人。您可选择不向我们提供所需的个人资料, 惟这样可能导致未能获得任何上述的服务。

Signature of Owner / Trustee 持有人 / 信托人签署 (Please do not sign on blank form and use the signature on our file. 请勿在空白表格上签署, 并确保签名与保单申请表一致)	Signature of Insured, if other than Owner / Trustee 投保人签署, 倘非持有人 / 信托人 (Please do not sign on blank form and use the signature on our file. 请勿在空白表格上签署, 并确保签名与保单申请表一致) (Whose age is 18 or above 年龄十八岁或以上必须签署)		
Name 姓名 <input style="width: 90%;" type="text"/>	Name 姓名 <input style="width: 90%;" type="text"/>		
ID Card / Passport Number 身份证 / 护照号码 <input style="width: 95%;" type="text"/>	Date 日期 <input style="width: 95%;" type="text"/>	ID Card / Passport Number 身份证 / 护照号码 <input style="width: 95%;" type="text"/>	Date 日期 <input style="width: 95%;" type="text"/>
Relationship with the Insured 与投保人关系 <input style="width: 95%; height: 40px;" type="text"/>	Signature of Witness 见证人签署 <input style="width: 95%; height: 40px;" type="text"/>		
		Name 姓名 <input style="width: 90%;" type="text"/>	Date 日期 <input style="width: 90%;" type="text"/>

**PART II TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SURGEON AT THE CLAIMANT'S OWN EXPENSES**  
**第二部分申请人自费由主诊医生 / 手术医生填写**

1. (a) Name of patient 病人姓名 <input style="width:95%;" type="text"/>	(c) Age 年龄 <input style="width:95%;" type="text"/>
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(b) ID Card / Passport Number 身份证 / 护照号码 <input style="width:95%;" type="text"/>	(d) Sex 性别 <input style="width:95%;" type="text"/>
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2. Hospitalization 住院  
 Name of hospital 医院名称:

Date of Admission 入院日期	MM	DD	YYYY	年	Date of Discharge 出院日期	MM	DD	YYYY	年
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Period in Intensive Care Unit 入住深切治疗部日期	From 由	MM	DD	YYYY	年	To 至	MM	DD	YYYY	年
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3. Chief complaints of the patient relating to this hospitalization / surgery / investigation 此次住院 / 手术 / 检验的主要原因

4. Date when symptoms first appeared or date when the accident occurred 首次出现病徵日期或意外发生日期	MM	DD	YYYY	年
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5. Date of first consultation for this condition or related illness 病人就此病症或相关疾病的首次求诊日期	MM	DD	YYYY	年
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6. Final diagnosis / Pathological diagnosis 最终诊断 / 病理诊断	ICD-10 code 国际疾病分类代码(ICD-10)
<div style="border: 1px solid black; width: 100%;"></div>	<div style="border: 1px solid black; width: 100%;"></div>

7. Medical / Surgical Procedure 医疗 / 手术程序	Date of Operation 手术日期
<div style="border: 1px solid black; width: 100%;"></div>	MM 月 DD 日 YYYY 年
Name of Procedure 手术名称 (please supplement with CPT code 请提供目前使用医疗服务术语代码)	
<div style="border: 1px solid black; width: 100%;"></div>	

8. Please answer the following questions if the insured requires hospitalization 若投保人需要住院，请回答以下问题

Can the medical test(s) and the procedure be done on an outpatient basis in hospital?  
 该检查及手术可否在医院的日间手术中心进行?  Can 可以  Cannot 不可以

If cannot, please give details 若不可以请详述

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), please specify 现时健康状况 (合并症)，请明确说明:

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

Expected higher post-operative risk, please specify 预期较高手术后风险，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:

Is it a case of emergency? 这是否紧急个案?  Yes 是  No 不是

If Yes, please specify 如是，请明确说明。

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9. Brief discharge summary (including treatments, investigation procedures, results and / or any complications and follow up plan)  
出院摘要：(治疗及以后治疗计划，包括诊查办法、结果，并发症及跟进计划)

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10. 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？

Yes 有  No 不是

If Yes, please state dates and details 如有，请说明何时及当时情况：

--

Dates  
日期

--	--

MM月

--	--

DD日

--	--	--	--

YYYY年

Treatment for the condition(s) 治疗详情

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11. Was the patient referred by another doctor?

病人是不是经其他医生转介？

Yes 是  No 不是

Name and address of the referral doctor 转介医生的姓名和地址：

--

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

病人患上癌症，请填写以下资料：

Yes 有  No 没有

- a) Please provide treatment regimen details of the patient including name of drugs, dosage, treatment delivery/ duration, frequency etc.  
请提供病人的癌症治疗方案包括药物名称、剂量、治疗方式、次数等资料

Radiotherapy 放射性治疗：

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Chemotherapy 化学治疗：

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Others (e.g. Hormone therapy, Targeted Therapies 其他治疗 (例如荷尔蒙治疗，标靶治疗)：

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- b) Any Cancer Genomics test done by the patient? 病人有否接受癌症基因检测？

- ACT Genomics 行动基因  
 FoundationOne 全方位癌症基因检测  
 Others 其他 \_\_\_\_\_

I / We hereby declare that the information given on this form is true to the best of my / our knowledge and belief.

本人 / 我们现声明此申请表上所填资料皆为本人 / 我们所知及所信之事实。

--

Name of Attending Physician / Specialist (with qualifications)  
主诊 / 专科医生的姓名 (资历)

--

Signature (with chop) 签名 (盖印)

--

Address and Telephone No. 地址及电话

--

Date 日期



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