



American International Assurance Company (Bermuda) Limited

美國友邦保險（百慕達）有限公司

AIA Tower, 183 Electric Road, North Point, Hong Kong. Tel: 2881 3514 Fax: 2577 4956



GROUP MEDICAL INSURANCE - HOSPITALIZATION & SURGICAL CLAIM FORM

團體醫療保險 — 住院及手術賠償申請表

This form is applicable to both inpatient and outpatient surgical claim

本表格適用於住院或門診手術賠償

PART 1 - TO BE COMPLETED BY THE PATIENT

甲部 — 由病人填寫

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|---|------------------|
| Name of Employer/Group Policyholder 僱主/團體保單投保公司名稱： | |
| Name of Insured Employee/Member 被保僱員/成員姓名： (For group insurance policy only) | Policy No. 保單編號： |
| Insured Employee's I.D. Card/Certificate No. 被保僱員/成員之身份證/被保證書編號： | |

| | | |
|-----------------------|----------------------|---|
| Name of Patient 病人姓名： | I.D. Card No. 身份證號碼： | |
| Occupation 職業： | Date of Birth 出生日期： | Sex 性別： <input type="checkbox"/> M 男 <input type="checkbox"/> F 女 |

Relationship to the Insured Employee/Member 與被保僱員/成員之關係：
 Self 本人 Spouse 配偶 Child 子女

(1) Have you /the claimant had any prior treatment for this or related conditions?
閣下/賠償申請人是否曾經因同一病況而接受治療？

NO 沒有 YES 有 Doctor's Name 醫生姓名：_____

Address 地址：_____

Date(s) 日期：_____

(2) Are you / the claimant making any other insurance claim as a result of this hospitalization/surgery?
有關此次住院/手術，閣下/賠償申請人是否有申請其他保險賠償？

NO 沒有 YES 有 Name of Insurance Company 保險公司名稱：_____

Policy No. 保單號碼：_____

(3) Was the hospitalization surgery a result of an accident?
此次住院/手術是否由於一宗意外引致？

NO 不是 YES 是 Date 日期：_____ Time 時間：_____ Place 地點：_____

Brief Description 經過：_____

| | |
|--|---|
| Note : | 注意： |
| (1) This form and relevant medical receipts must be submitted to AIA within 3 months from the claim incurred date. Otherwise, the claim shall be declined for reimbursement. | (1) 在支付醫療費後三個月內，索償人必須將此申請表連同有關收據寄予本公司處理，逾期無效。 |
| (2) Claim payment will be subject to the terms and conditions set out in the corresponding Group policy. | (2) 一切賠償款項將根據有關保單上的條文計算。 |
| (3) Incomplete form or omission of required information may cause delay in processing. | (3) 若此申請表未完全填妥或未有提供足夠理賠資料，是次賠償處理將被延誤。 |

| | | |
|---|--|---|
| <p>Declaration and Authorization</p> <p>I / We hereby declare and agree that any personal information collected or held by the Company (whether contained in this application or otherwise obtained) is provided and may be held, used, and disclosed by the Company to individuals / organizations associated with the Company or any selected third party (within or outside of Hong Kong, including reinsurance and claims investigation companies and industry associations / federations) for the purposes of processing this application and providing subsequent services, and data matching, and to communicate with me / us for such purposes. I / We understand that I / we have the right to obtain access to and to request correction of any personal information held by the Company concerning me / us (and my / our dependents, if any). Such request can be made to the Company's Group Insurance Department. I / We also hereby irrevocably authorize:</p> <p>(i) any organization, institution, or individual that has any record or knowledge of my/the Insured(s)'s health and medical history or any treatment or advice and that has been or may hereafter be consulted to disclose to the Company such information. This authorization shall bind my / the Insured(s)'s successors and assigns and remain valid notwithstanding my / the Insured(s)'s death or incapacity in so far as legally possible. A photocopy of this authorization shall be as valid as the original.</p> <p>(ii) the Company or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests to underwrite and evaluate my / the Insured(s)'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.</p> | <p>聲明及授權</p> <p>本人/我們現聲明並同意，貴公司可保留、使用或透露貴公司所收集或保留之任何有關本人/我們的個人資料（在此申請書所載或從其他途徑取得），給予與貴公司有關的人士/機構或任何被選定的機構（在本港或海外的，包括再保險及賠償調查公司，及有關的行業協會/聯會），用作處理本申請及提供其稍後的服務，及資料核對等用途，及因此等用途與本人/我們聯絡。本人/我們明白到本人/我們有權向貴公司查閱及申請改正所有與本人/我們（及本人/我們的受贍養者，如適用）的個人資料。有關的申請可於貴公司的團體保險部辦理。</p> <p>本人/我們茲授權：</p> <p>(i) 任何知悉或擁有本人/被保人之健康狀況及病歷或任何治療或諮詢記錄及曾為或將為本人/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/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/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。</p> <p>(ii) 貴公司或任何其認可之驗身醫生或化驗所，替本人/被保人進行所需之醫療評估及測試，並對本人/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、尼古丁及其代謝物之含量等化驗。</p> | |
| Date 日期 | Signature of Insured Employee/Member 被保僱員/成員簽署 | Signature of Claimant 18 Years of Age & Over 賠償申請人（十八歲以上）簽署 |

PART II - TO BE COMPLETED BY THE SURGEON OR ATTENDING PHYSICIAN

Patient Name: _____ Age: _____ HKID Card No.: _____
 病者姓名 年齡 香港身份証號碼

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| <p>1. What was the period of hospitalization?</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border-bottom: 1px solid black;">Admission Date</td> <td style="width: 50%; border-bottom: 1px solid black;">Discharged Date</td> </tr> <tr> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> </tr> <tr> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> </tr> <tr> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> </tr> </table> | Admission Date | Discharged Date | | | | | | | <p>7 a. Have you treated the above patient for this or related sickness before?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes, please give details _____</p> <p>_____</p> <p>b. Was the condition a recurrent episode or a chronic disease? If YES, when was the date of first attack?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes, it was _____</p> <p style="text-align: center;">the date of first attack was on _____</p> <p>_____</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Admission Date | Discharged Date | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <p>2 a. Please give chief complaint/diagnosis for this hospitalization.</p> <p>_____</p> <p>b. Describe the type of treatment/surgical procedure given to the patient.</p> <p>_____</p> <p>_____</p> | <p>8. Was the condition caused by or in anyway associated with the conditions mentioned below?</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">Conditions</td> <td style="width: 5%;"></td> <td style="width: 5%; text-align: center;">Yes</td> <td style="width: 5%; text-align: center;">No</td> </tr> <tr> <td>a. the influence of drugs or alcohol intake?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>b. AIDS, venereal disease or sexually transmitted disease?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>c. infertility or sterilization?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>d. cosmetic or plastic surgery?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>e. mental or nervous disorder?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>f. congenital deformities or anomalies?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>g. suicide, insanity or self-infliction?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>h. correction of eye sight?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> | Conditions | | Yes | No | a. the influence of drugs or alcohol intake? | <input type="checkbox"/> | | <input type="checkbox"/> | b. AIDS, venereal disease or sexually transmitted disease? | <input type="checkbox"/> | | <input type="checkbox"/> | c. infertility or sterilization? | <input type="checkbox"/> | | <input type="checkbox"/> | d. cosmetic or plastic surgery? | <input type="checkbox"/> | | <input type="checkbox"/> | e. mental or nervous disorder? | <input type="checkbox"/> | | <input type="checkbox"/> | f. congenital deformities or anomalies? | <input type="checkbox"/> | | <input type="checkbox"/> | g. suicide, insanity or self-infliction? | <input type="checkbox"/> | | <input type="checkbox"/> | h. correction of eye sight? | <input type="checkbox"/> | | <input type="checkbox"/> |
| Conditions | | Yes | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <p>3. When were the symptoms first presented or when did the accident happen?</p> <p>_____</p> | <p>9. If the treatment is due to pregnancy, please give the date of conception.</p> <p style="text-align: center;">_____ MM _____ DD _____ YY</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>4 a. When was the first consultation for this treatment/sickness?</p> <p>_____</p> <p>b. Has the patient received continuous treatment related to this sickness since then?</p> <p>_____</p> | <p>10 a. Is the hospitalization/treatment medically necessary?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes, please give details _____</p> <p>_____</p> <p>b. For the average patient, what is the usual duration of hospitalization for this sickness?</p> <p>_____</p> <p>c. Is it possible to provide this treatment on an outpatient basis?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes, please give details _____</p> <p>_____</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>5. If hospitalization was due to accident, please state how did it happen.</p> <p>_____</p> <p>_____</p> | <p>11. Did any complications arise during hospitalization?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes, please give details _____</p> <p>_____</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>6. Was the patient referred to you by another doctor? If YES, please give name and address of the doctor.</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border-bottom: 1px solid black;">Doctor's Name</td> <td style="width: 50%; border-bottom: 1px solid black;">Address</td> </tr> <tr> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> </tr> <tr> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> </tr> </table> | Doctor's Name | Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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 Name of Attending Physician / Specialist (with qualifications)
 主診/專科醫生的姓名 (資歷)

 Address 地址

 Telephone 電話

 Signature of Attending Physician / Specialist
 主診/專科醫生簽名

 Date 日期