AMERICAN INTERNATIONAL ASSURANCE CO. (BERMUDA) LTD.
美國友邦保險（百慕達）有限公司

Group Insurance Department
13/F., AIA Tower, 183 Electric Road,
North Point, Hong Kong.
Telephone: 2838 3510

GROUP CLINICAL BENEFIT CLAIM FORM
團體保險門診醫藥賠償申請表

Name of Employer/Group 僱主／團體名稱	Group Policy No. 團體保單編號	Contact Tel. No. (daytime): 日間聯絡號碼
Name of Insured Employee/Member 受保僱員／成員姓名	Certificate No./I.D. No. 受保證書編號／身份證編號	

Relationship to Insured Employee/Member 與受保僱員／成員之關係	Name of claimant (i.e. Patient) if other than Insured Employee/Member 賠償申請人（即病者）姓名，如與受保僱員／成員非同一人	Total Amount of Claim 申請賠償之總數
☐ Spouse 配偶	Surname 姓	
☐ Children 子女	Given Name 名	

Declaration & Authorization
聲　明　及　授　權　書

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:

a. 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.

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/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, test 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.

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逕取得），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。

本人／我們茲授權：

a. 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。

b. 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、尼古丁及其代產物之含量等化驗。

____
Signature of Claimant 18 years of age & over 賠償申請人（十八歲或以上）簽署

____
Signature of Insured Employee/Member 受保僱員／成員簽署

____
Date Signed 簽署日期

GPOPCF01. 0502 (PTA000063)

Instructions:

1. This form is to be completed in block letter by the Insured Employee/Member and separate forms must be used for different claimants (i.e. patients)
此申請表由受保僱員／成員以正楷填寫，每表祇限一位賠償申請人（即病者）使用。

2. Claim for clinical expenses must be submitted within 3 months from incurring such expenses. Otherwise, the claims will be declined for reimbursement.
門診費用賠償應於三個月內申請。否則賠償會被拒絕接受辦理。

3. Original bills or receipts for the claimed expenses must be attached showing the date of treatment, patient's name, diagnosis, and the attending physician's stamp and signature.
須附詳細門診費用賬單或收據正本，提供治療日期，病者姓名，病症及主治醫生之印監及簽署。

4. Claim for expenses incurred in buying medicines/drugs and/or claim for undergoing X-ray examination/laboratory tests must be supported by the attending physician's prescription and/or recommendation and the original bills/receipts from the pharmacist and/or laboratory.
申請賠償購買藥物或X光／醫學檢驗費用須附具主診醫生之處方或認可及藥房或化驗室之賬單或收據正本。

5. No benefit is payable for the conditions listed under **"LIMITATIONS AND EXCLUSIONS"** of the master policy, common items of which are listed below.
如費用原於保單內所列的「限制情況和不保事項」恕不受保。一些普遍及基本的限制如下。

6. Claim payment will be subject to the terms and conditions set out in the corresponding Group policy.
一切賠償款項將根據有關保單上的條文計算。

7. Incomplete form or omission of required information may cause delay in processing.
若此申請表未完全填妥或未有提供足夠理賠資料，賠償處理將被延誤。

BASIC LIMITATIONS
基　本　限　制　條　款

No benefit is payable for the following items:
下列各項不在受保範圍之內：

(a) Treatment by any person other than a physician in western medicine.
非註冊西醫所作之治療。

(b) Medicines/drugs purchased and X-ray examinations or laboratory tests taken, unless the expenses incurred are as a result of clinical consultations for which benefits are payable under the policy and are supported by a physician's medicine prescription and/or recommendation.
非註冊西醫處方購買之藥物或非經註冊西醫認可之X光檢查或醫學檢驗。

(c) Congenital anomalies; treatment relating to birth control sterility or infertility, sterilization of either sex.
先天性異常；節育或不育之治療；絕育手術。

(d) Condition or treatment related to and/or resulting from pregnancy.
懷孕引致之情況

(e) Treatment of psychological or emotional conditions; rest cures or sanitaria care; drug addiction or alcoholism.
有關心理或情緒的治療；休養或療養；濫用藥物或酗酒的治療。

(f) Any dental care or treatment or surgery unless necessitated by damage to sound natural teeth as a result of an accident.
任何牙科治療或手術，但因意外而損傷本身牙齒者除外。

(g) General physical or medical check-up; eye refractions; fitting of glasses, contact lenses or hearing aids.
例行體格檢查；屈光；配眼鏡或助聽器。

(h) Cosmetic treatment or surgery for purpose of beautification or plastic surgery.
美容治療或整容手術。

(i) Non-medically necessary treatment.
非醫療所需的服務。