



# Accident & Health Insurance Claim Form

## 意外及醫療保險索償申請表

This form must be completed truthfully and accurately. If the space is not enough or no applicable field available, please supplement information by attachment.  
請正確填寫此申請表。如果表格空間不足或沒有適用之欄位，請以附件補充資料。

The list of documents required is not exhaustive and we reserve our right to request from you any additional information/documentation, as necessary.

The submission of an incomplete form or insufficient information or supporting documents may delay the processing or result in the denial of your claim.

各部份之「所需文件」只是概括要求，本公司保留權利在有需要時要求閣下提供更多文件以處理有關的索償申請。如所述交的索償申請表未填妥或有關資料或文件不足，閣下的索償申請有可能會受延誤或被拒絕。

The completed form should be returned to us together with all supporting documents within thirty (30) days after the occurrence at the following address:

請填妥索償申請表並連同所有有關文件於事件發生後三十(30)天內寄回以下地址：

AIG Insurance Hong Kong Limited  
Claims Department  
7/F One Island East 18 Westlands Road Island East Hong Kong  
Telephone: 852 3666 7090  
Facsimile: 852 2834 8962  
Email address: pa.claim.hk@aig.com  
www.aig.com.hk

美亞保險香港有限公司  
賠償部  
香港港島東華蘭路18號港島東中心7樓  
電話：852 3666 7090  
傳真：852 2834 8962  
電郵地址：pa.claim.hk@aig.com  
www.aig.com.hk

### Section 1 – General Information (REQUIRED) 第一部份 受保人及一般資料 (必須填寫)

Policy/certificate no. 保單號碼		Name of Policyholder (English) 保單持有人姓名(英文)		Name of Policyholder (Chinese) 保單持有人姓名(中文)	
Name of Insured (English) 受保人姓名(英文)		Name of Insured (Chinese) 受保人姓名(中文)		Insured's HKID No./Passport No 受保人香港身份證/護照號碼	
Name of Claimant (English) 索償申請人姓名(英文)		Name of Claimant (Chinese) 索償申請人姓名(中文)		Claimant's HKID No./Passport No 香港身份證/護照號碼	
Relationship between Claimant & Insured 索償申請人與受保人關係		Only applicable for fatal case 只適用於死亡個案		Only applicable for fatal case 只適用於死亡個案	
Name of Parent/Legal Guardian (English) 父母/合法監護人姓名(英文)		Name of Parent/Legal Guardian (Chinese) 父母/合法監護人姓名(中文)		Parent/Legal Guardian's HKID No./Passport No 父母/合法監護人香港身份證/護照號碼	
Only applicable if the Insured is below the age of 18 只適用於受保人未滿18歲的情況		Only applicable if the Insured is below the age of 18 只適用於受保人未滿18歲的情況			
E-mail Address 電郵地址		Mobile Phone No. 手提電話號碼		Insured's Occupation 受保人職業	
		Claim acknowledgement will be sent to this mobile phone number via SMS upon receipt of claim form. 本公司將會在收到此索償申請後發送確認短訊至此手提電話號碼			
Mailing Address 通訊地址					
Are you a citizen of the United States? 閣下是否美國公民？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否				If yes, please provide your social security number 如是，請提供社會保障編號	
AIG HK is a subsidiary of US company and as such is required to report injury claims of U.S. citizens who may be eligible to receive "Medicare" (pursuant to the Medicare, Medicaid & SCHIP Extension Act of 2007). This information is requested solely to enable us to comply with this reporting requirement. 美亞保險香港有限公司作為美資公司的附屬公司，根據美國法案Medicare, Medicaid & SCHIP Extension Act of 2007，需要匯報所有由有資格享有美國公共醫療保險的美國公民提出的受傷索償。此項資料僅為遵從以上匯報要求而收集。					
Claim Type (please tick) 索償類別 (請選擇) <input type="checkbox"/> New Claim 新的索償 <input type="checkbox"/> Further Claim, with Claim Number: 再度索償，索償檔案編號: _____					
Claim Item (please tick) 索償項目 (請選擇) <input type="checkbox"/> Accidental Medical Expenses 意外醫療費用 <input type="checkbox"/> Critical Illness 危疾 <input type="checkbox"/> Broken Bone 骨折 <input type="checkbox"/> Hospital Income 住院現金 <input type="checkbox"/> Permanent Disability 永久傷殘 <input type="checkbox"/> Other, please specify 其他，請詳述： <input type="checkbox"/> Hospital Expenses 住院醫療費用 <input type="checkbox"/> Accidental Death 意外死亡					
Amount 索償金額 HK\$ _____					
Claim Amount for Medical Expense 醫療費用索償金額					
Amount of Chinese medical treatment receipt(s) 中醫門診金額 HK\$ _____ X _____ Pieces 張 = HK\$ _____					
Amount of out-patient Western medical treatment receipt(s) 西醫門診金額 HK\$ _____ X _____ Pieces 張 = HK\$ _____					
Amount of hospital receipt(s) 住院金額 HK\$ _____ X _____ Pieces 張 = HK\$ _____					
Total receipts amount 收據總額 HK\$ _____					
Do you have any other insurance policies covering this loss or expenses incurred? 是項索償項目是否受保於其他保險合約？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否					
If yes, please provide the details below 如是，請提供以下資料： Name of Insurer 保險公司之名稱 _____ Policy No. 保單編號 _____ Policy Type 保單類別 _____ Sum Insured 保額 _____					
<input type="checkbox"/> Please "✓" this box for return of Certified True Copy ("CTC") of your original medical receipts after claim is finalized. Original medical receipts will not be returned regardless you tick the box or not. 如欲在完成此索償個案後索回醫生的發票和收據正式影印副本，請在空格內填上「✓」號。不論閣下是否填上此空格，正本文件也將不獲發還。					

Section 2- Claims Payment Mode (Required) (Please tick)

第二部份 賠償支付方式 (請選擇) (必須填寫)

The request for payment mode is not an admission of our liability. If the claim is eligible, the payment shall be payable to the relevant Insured only based on the following details provided.

本公司特此聲明此項要求並不代表本公司承認賠償責任。如果索償成功，所有賠償均只可支付予此索償之相關受保人如下提供的信息。

- Notice:
1. Purpose for collection: (i) Solely to enable AIG HK to effect settlement payment for eligible claim(s). (ii) AIG HK shall only make payment according to the details provided in this section.

2. We will facilitate payment by HKD cheque delivered to the Policy Holder's/eligible Claimant's mailing address if we cannot proceed with the selected payment method.

3. AIGHK reserves the right to determine the claim payment method at its absolute discretion.
- 注意事項:
1. 收集目的：(i) 僅使美亞保險能夠對符合條件的索償進行賠償付款。(ii) 美亞保險將只會根據以下提供的資料進行付款。

2. 如無法使用以下所選擇的支付方式，美亞保險會以港幣支票作為賠償方式並郵寄往受保人/符合條件的索償者的通訊地址。

3. 美亞保險保留自行決定其索償款項的付款方法的權利。

Please choose one. 請選擇其一	<input type="checkbox"/> Faster Payment System (FPS) 快速支付系統 (「轉數快」)	**Only applicable for claims payment amount under HKD5,000. **只適用於不超過港幣5,000 元的索償支付金額之個案。
	<input type="checkbox"/> Direct credit to Hong Kong Bank Account (HKD account only) 支付到銀行帳戶 (只限港幣戶口)	
	<input type="checkbox"/> Hong Kong Dollar Cheque 港幣支票	

If you choose **Faster Payment System (FPS)** for your claim(s), please complete the following: 如選擇使用 **快速支付系統 (「轉數快」)** 為你的賠償支付方式，請填寫以下資料：

Notice:		注意事項:	
1. Please ensure the proxy (phone number/e-mail address/FPS ID) you've provided is already registered with Faster Payment System, otherwise the payment cannot proceed.		1. 請確保以下提供的識別代號 (電話號碼/電郵/快速支付系統識別碼) 已在快速支付系統中註冊，否則無法進行付款。	
2. Claims Payment can only be addressed to Policy Holder /eligible Claimant. Please ensure the registered proxy with bank account holder's name is the same as the name of Policy Holder/ eligible Claimant(s), otherwise the payment cannot proceed.		2. 賠償付款僅支付給保單持有人/符合條件的索償者。請確保註冊快速支付系統的銀行帳戶持有人姓名與保單持有人/符合條件的索償者姓名相同，否則無法進行付款。	
3. Please provide <b>One (1)</b> of the proxy (phone number /e-mail address/FPS ID) in below field.		3. 請於下面只提供 <b>一個</b> 快速支付系統識別代號 (電話號碼 /或 電子郵件地址 /或 快速支付系統識別碼)。	
4. Please provide <b>e-mail address</b> for sending Claim statement, otherwise the payment cannot proceed.		4. 請提供 <b>電子郵件地址</b> 以發送賠償明細表，否則無法進行付款。	
FPS Account Holder's Name FPS帳戶持有人姓名		E-mail address 電郵地址	
Claim statement will be sent to this e-mail address upon payment 賠償明細表將發送到此電郵地址			
(FPS) Telephone no. (轉數快) 電話號碼	+852	或 or	(FPS) E-mail address (轉數快) 電郵地址
或 or		或 or	FPS ID 快速支付系統識別碼

或 or

If you choose **Direct credit to Hong Kong Bank Account** for your claim(s), please complete the following: 如選擇使用 **支付到銀行帳戶** 為你的賠償支付方式，請填寫以下資料：

Notice:		注意事項:	
1. Please provide a <b>copy of bank passbook or ATM card</b> , otherwise the payment cannot proceed.		1. 請提供 <b>銀行存摺 或 提款卡副本</b> ，否則無法進行付款。	
2. Claims Payment shall only be addressed to Policy Holder/ eligible Claimant. Please ensure the bank account holder's name is the same as the name of Policy Holder/ eligible Claimant(s), otherwise the payment cannot proceed.		2. 賠償付款僅支付給保單持有人/符合條件的索償者。請確保銀行帳戶持有人姓名與保單持有人/符合條件的索償者姓名相同，否則無法進行付款。	
3. Please provide <b>e-mail address</b> for sending Claim statement, otherwise the payment cannot proceed.		3. 請提供 <b>電子郵件地址</b> 以發送賠償明細表，否則無法進行付款。	
Account Holder's Name 戶口持有人姓名		Bank Name 銀行名稱	
Bank Code 銀行號碼	<input type="text"/>	Branch Code 分行號碼	<input type="text"/>
Account Number 戶口號碼	<input type="text"/>	<input type="text"/>	
E-mail address 電郵地址		Claim statement will be sent to this e-mail address upon payment 賠償明細表將發送到此電郵地址	

Documents required:

**Accident Medical Expenses**

- Completion of Claim Form Section 3
- Original receipt(s) with diagnosis.

**Hospital Income**

- Hospital Statement
- Completion of Claim Form Section 3
- Completion of Claim Form Section 4 (Applicable to private hospital)
- Discharge Slip / Discharge Summary (Applicable to HK government hospital)

**Hospital Expenses**

- Original hospital statement and receipts
- Completion of Claim Form Section 3
- Completion of Claim Form Section 4 (Applicable to private hospital)
- Discharge Slip / Discharge Summary (Applicable to HK government hospital)

**Accidental Death & Disablement**

- Completion of Claim Form Section 3
- Police report, if applicable
- Documentary proof certifying the insured is suffering from permanent disability (applicable for permanent disability claim)
- Copy of Death Certificate indicating the cause of death (applicable for death claim)
- Grant of Probate / Letters of Administration

**Critical Illness**

- Completion of Claim Form Section 3
- All relevant medical and examination report regarding the claimed Critical Illness

**Hong Kong Bank Transfer**

- Copy of bank passbook or card

If the medical expenses were claimed from another insurer or organization, please also provide their claim statement.

所需文件：

**意外醫療費用**

- 填妥索償表格第三部份
- 連同診斷證明之醫療費用收據正本

**住院現金**

- 醫院收費清單
- 填妥索償表格第三部份
- 由醫生填妥的索償表格第四部份 (適用於私家醫院)
- 出院摘要 / 出院總結 (適用於香港公立醫院)

**住院醫療費用**

- 正本醫院收費清單及收據
- 填妥索償表格第三部份
- 由醫生填妥的索償表格第四部份 (適用於私家醫院)
- 出院摘要 / 出院總結 (適用於香港公立醫院)

**意外死亡及傷殘**

- 填妥索償表格第三部份
- 警方報告，如適用
- 證明受保人永久傷殘的有關醫療報告 (適用於永久傷殘索償)
- 證明死因之死亡證明書 (適用於意外死亡索償)
- 授予遺囑認證書 / 遺產管理書

**危疾**

- 填妥索償表格第三部份
- 有關危疾的所有醫療及檢查報告

**本地銀行過數**

- 銀行存摺或提款卡副本

如果醫療費用曾在其他保險公司或機構索償，請提供有關賠償紀錄。

Section 3 – Details of Injury/Sickness

第三部份 意外/疾病詳情

Date and time of the injury/sickness 發生意外或疾病的日期及時間			Date of first consultation with doctor/hospital 第一次求診日期			Nature of injury/Diagnosis of sickness 傷勢/病況的診斷結果							
DD 日	MM 月	YYYY 年	<input type="checkbox"/> A.M. 上午	<input type="checkbox"/> P.M. 下午	DD 日	MM 月	YYYY 年						
Part of body affected 身體受傷部位			In the case of injury, where and how did the accident occur? In the case of sickness, what were the symptom(s) and when did the symptom(s) first appear? 如屬受傷個案，請詳述意外地點及發生經過。如屬疾病個案，請說明病徵及首次出現病徵的時間。										
Name of the attending doctor 主診醫生姓名			Address of the attending doctor 主診醫生地址										
Name of Witness(es) (Applicable to Injury Claim) 證人姓名 (適用於意外個案)			Address of Witness(es) (Applicable to Injury Claim) 證人地址 (適用於意外個案)				Address of Witness(es) (Applicable to Injury Claim) 證人電話 (適用於意外個案)						
Was the injury due to any other person's fault? 如屬受傷個案，請說明是否因為任何第三者的過錯。 <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否			If yes, please provide the details of the third party, including the name, address and contact number. 如是，請提供有關第三者的姓名、地址/電話										
Did this accident occur in the course of and/or arising out of employment? 意外是否在受僱期間因工作引致？  <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否			If yes, please state the name of insurance company for Employees Compensation Insurance and the Policy No. 如是，請提供僱員補償保險的保險公司名稱及保單編號										
			Period of sick leave granted by attending physician 主診醫生發出病假時期			FROM 由	DD 日	MM 月	YYYY 年	TO 至	DD 日	MM 月	YYYY 年
Do you need to receive further medical treatment? 你是否需要繼續接受治療？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否			If yes, how long will the further medical treatment last? 如是，該療程還需多長時間？										

Section 4 – Attending Physician Statement (To be completed by attending physician)

Applicable to Private Hospital Confinement

第四部份 主診醫生報告 (由主診醫生填寫) 適用於入住私家醫院之索償

Patient's information 病人資料															
Name (English) 姓名(英文)				Age 年齡				HKID No./Passport No. 香港身份証/護照號碼							
Patient's medical history 病人病史															
Date of injury occurred or symptom(s) first appeared 受傷或首次出現病徵日期  DD 日    MM 月    YYYY 年				Date of first consultation with you 閣下首次診治日期  DD 日    MM 月    YYYY 年				Was the patient referred by any other doctor? 是次情況是否由其他醫生轉介？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否							
Diagnosis 診斷								If yes, please state name of the doctor 如是，請提供轉介醫生姓名：  Date of first consultation with referring doctor 轉介醫生首次診治日期  DD 日    MM 月    YYYY 年							
To the best of your knowledge, has the patient ever had the same or similar condition(s) or symptom(s)? 據你所知，病人以往曾否出現同樣或類似的病況？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 If yes, please state dates and conditions / symptoms 如是，請提供日期及詳情：  _____								Was the condition caused by any underlying disease? 是次情況是否由其他潛在疾病導致？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 If yes, please state dates and conditions / symptoms 如是，請提供日期及詳情：  _____							
Is the diagnosis due to or associated with any of the following? 診斷是否由下列情況導致或者有關？															
(a) Congenital anomalies? 先天性異常				<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否				(e) Refractive error or correction of eyesight? 視力矯正				<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否			
(b) Heredity condition? 遺傳性疾病				<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否				(f) Cosmetic or plastic surgery? 美容或整形手術				<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否			
(c) Pregnancy or childbirth? 懷孕或分娩				<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否				(g) Routine medical check-up? 例行醫療檢查				<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否			
(d) Drugs or alcohol? 酒精或藥物影響				<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否				(h) Mental or nervous disorders? 精神或心理病				<input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否			

Name of hospital 醫院名稱																					
Date of admission 入院日期				DD 日		MM 月		YYYY 年		Date of discharge 出院日期		DD 日		MM 月		YYYY 年					
Major complaints of the patient 病人主要病徵																					
In the case of injury, were the patient's complaints solely caused by this current accident? If not, is there any connection with a previous accident or any other causes? Please specify. 如屬受傷個案，病人之主要病徵是否只因最近之意外引致? 如不是，這會否與之前之意外或其他原因有關? 請提供詳情。																					
Brief discharge summary (including treatments, investigation procedures, results, and/or any complications and follow-up plan) 出院概況 (包括診治、檢查程序、結果、併發症及覆診計劃)																					
If the patient had a surgical procedure, please fill in the boxes below 如果病人有接受手術，請提供																					
Name and nature of the procedure 手術名稱及性質												DD 日						MM 月		YYYY 年	
Declaration 醫生聲明 I hereby certify that the facts given above are true to the best of my knowledge. 本人在此證明以上所有事實是根據本人所知及正確無誤。																					
Name of attending physician/specialist 主診醫生姓名										Signature and chop 簽名及蓋章											
Qualifications 專業資格										Hospital 醫院											
Telephone no. 電話號碼										Date 日期				DD 日		MM 月		YYYY 年			

09/2020( update 10/2021)