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。如所遞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 as soon as possible at the following address:
請填妥索償申請表並連同所有有關文件盡快寄回以下地址：

AIG Insurance Hong Kong Limited
Claims Department
46/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46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 I – 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 受保人香港身份証/護照號碼：

Name of Claimant (English)(Only applicable for fatal case) 索償申請人姓名(英文) (只適用於死亡個案)	Name of Claimant (Chinese)(Only applicable for fatal case) 索償申請人姓名(中文) (只適用於死亡個案)	Claimant's HKID No/Passport No 索償申請人香港身份証/護照號碼：	Relationship between Claimant & Insured 索償申請人與受保人關係：

Name of Parent/Legal Guardian (English) Only applicable if the Insured is below the age of 18 父母/合法監護人姓名(英文) 只適用於受保人未滿18歲的情況	Name of Parent/Legal Guardian (Chinese) Only applicable if the Insured is below the age of 18 父母/合法監護人姓名(中文) 只適用於受保人未滿18歲的情況	Parent/Legal Guardian's HKID No/Passport No 父母/合法監護人香港身份証/護照號碼：

E-mail Address 電郵地址：	Mobile Phone No.手提電話號碼： Acknowledgement will be sent to this mobile phone number via SMS upon receipt of this form. 本公司將會在收到此索償申請表後發送確認短訊至此手提電話號碼。	Insured's Occupation 受保人職業：

Mailing Address 通訊地址：

Are you a citizen of the United States? 閣下是否美國公民？ ☐ Yes 是 ☐ 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，需要(根據美國法案Medicare, Medicaid & SCHIP Extension Act of 2007)匯報所有由有資格享用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)
☐ New Claim 新的索償　☐ 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)

☐ Accidental Medical Expenses 意外醫療費用
☐ Hospital Income 住院現金
☐ Hospital Expenses 住院醫療費用
☐ Critical Illness 危疾
☐ Permanent Disability 永久傷殘
☐ Accidental Death 意外死亡
☐ Broken Bone 骨折
☐ Other, please specify 其他，請詳述：

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？
☐ Yes 是　☐ 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_____

Means of Claim Settlement (Please tick) 賠償支付方式（請選擇）

We must emphasize that this request is not an admission of our liability. If the claim is eligible, the indemnity shall be payable to the relevant Insured only. *We will facilitate payment by HKD cheque delivered to the mailing address if e-mail address or copy of bank passbook / ATM card are not 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。如果沒有填寫電郵地址或提供銀行存摺/提款卡副本，本公司會以港幣支票作為賠償方式並郵寄往通訊地址。

☐ Hong Kong Bank Transfer 本地銀行過數

HKD account only. **Please provide your E-mail Address & copy of bank passbook or ATM card if you perfer payment by bank transfer.**
只限港幣戶口，**如閣下選擇銀行過數，請填寫電郵地址及提供銀行存摺或提款卡副本**

We will facilitate payment by HKD cheque delivered to the mailing address if e-mail address is not provided.
如果沒有填寫電郵地址，本公司會以港幣支票作為賠償方式並郵寄往通訊地址。

☐ Hong Kong Dollar Cheque 港幣支票
☐ Foreign Currency Cheque 外幣支票
Please specify the currency preferred **請註明所需外幣**

(Not available for RMB or MYR **不適用於人民幣或馬幣**)

Account Holder's Name (Must be the Insured or Insured's Parent/ Legal Guardian if the Insured is below the age of 18)
戶口持有人姓名 (必須為受保人或受保人之未滿18歲受保人的父母/合法監護人)：

Bank Name 銀行名稱：

E-mail Address (if different from above)
電郵地址 (如跟上頁所填寫的不同)

Notification of payment will be sent ot this email address賠款通知將會發送到此電郵地址

Bank Code 銀行號碼	Branch Code 分行號碼	Account Number 戶口號碼

Documents required

Accident Medical Expenses:
• Original receipt(s) with diagnosis.
Hospital Income:
• Hospital Statement
• Completion of Claim Form Section III (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 III (Applicable to private hospital)
• Discharge Slip / Discharge Summary (Applicable to HK government hospital) **Accidental Death & Disablement:**
• 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 III
• 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:
• 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
• 由醫生填妥的索償表格第三部份 (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
• 由醫生填妥的索償表格第三部份 (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:
• 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)
• 證明死因之死亡證副本 (適用於意外死亡索償)
• 授予遺囑認證書 / 遺產管理書
危疾:
• 由醫生填妥的索償表格第三部份 (適用於私家醫院)
• 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 II – Details of Injury / Sickness 第二部份　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 DD 日 / MM 月 / YYYY 年 / ☐ A.M. ☐ P.M. 上午 / 下午	Date of first consultation with doctor/hospital 第一次求診日期 DD 日 / MM 月 / YYYY 年	Nature of injury/Diagnosis of sickness 傷勢/病況的診斷結果

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。

Part of body affected 身體受傷部位	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)	Contact number 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，請說明是否因爲任何第三者的過錯。 ☐ Yes 是 ☐ 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？ ☐ Yes 是 ☐ 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 Form 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？ ☐ Yes 是 ☐ No 否	If yes, how long will the further medical treatment last? 如是，該療程還需多長時間？

Section III - Attending Physician Statement (To be completed by attending physician)
Applicable to Private Hospital Confinement
第三部份 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 :	ID Card No. / Passport No 身份證/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 ? ☐ Yes 是 ☐ No 否 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
Diagnosis 診斷 :		

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? ☐ Yes 是 ☐ 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 ? ☐ Yes 是 ☐ No 否 If yes, please specify : 如是，請提供詳情:

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	☐ Yes 是 ☐ No 否	(e) Refractive error or correction of eyesight? 視力矯正	☐ Yes 是 ☐ No 否
(b) Heredity condition? 遺傳性疾病	☐ Yes 是 ☐ No 否	(f) Cosmetic or plastic surgery? 美容或整形手術	☐ Yes 是 ☐ No 否
(c) Pregnancy or childbirth? 懷孕或分娩	☐ Yes 是 ☐ No 否	(g) Routine medical check-up? 例行醫療檢查	☐ Yes 是 ☐ No 否
(d) Drugs or alcohol? 酒精或藥物影響	☐ Yes 是 ☐ No 否	(h) Mental or nervous disorders? 精神或心理病	☐ Yes 是 ☐ 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 :	Date of the operation 手術日期 : 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。

Signature and chop 簽名及蓋章 :	Name of attending physician/specialist 主診醫生姓名 :	Date 日期 : DD 日 MM 月 YYYY 年

Qualifications 專業資格 :	Telephone no. 電話號碼 :	Hospital 醫院 :

Section IV – Declaration and Authorization 第四部份 聲明及授權

A. The undersigned Insured(s) / Claimant(s) HEREBY DECLARE that to the best of the Insured(s') / Claimant(s') knowledge and belief, the above statement and particulars contained are true and complete in every respect and are made without reservation of any kind.

B. In relation to the personal data collected in this claim form, the Insured(s)/Claimant(s) agree and acknowledge that:
   (a) (unless specifically indicated otherwise in this form) the personal data requested in this form (or otherwise provided during the course of the claim process) is necessary for AIG Insurance Hong Kong Limited ("AIG HK") to process the insurance claim and any such data not provided may mean the claim cannot be processed.
   (b) the personal data collected in this form may be used by AIG HK for purposes which include 1) assessing, investigation, adjusting and making a decision on this claim; 2) otherwise for the purpose of administering the insured(s') insurance policy (including pursuing recovery from reinsurers) and 3) for other purposes stated elsewhere in this form.
   (c) AIG HK may transfer the personal data to the following classes of persons (whether based in Hong Kong or overseas) for the purposes identified in (b) above:
      i) third parties providing services related to the administration of the Insured's policy (including reinsurers);
      ii) financial institutions for the purpose of processing this application and obtaining policy payments;
      iii) loss adjustors, assessors, third party administrators, emergency providers, legal services providers, retailers, medical providers and travel carriers;
      iv) another member of the AIG group (for all of the purposes stated in (b)) in any country; or
      v) other parties referred to in AIG HK's Data Privacy Policy for the purposes stated therein.
   (d) The Insured(s)/Claimant(s) may gain access to, or request correction of their personal data (in both cases, subject to a reasonable fee)at any time, by writing to the Privacy Compliance Officer of AIG Insurance Hong Kong Limited at GPO Box 456 or cs.hk@aig.com. The same addresses may be used to contact us with any comments on our service. The full version of AIG HK's Data Privacy Policy can be found at www.aig.com.hk.

C. The Insured(s) / Claimant(s) hereby irrevocably authorize:
   (a) any organization, institution, or individual that has any information, record or knowledge of the Insured(s') health and medical history or any treatment or advice rendered thereto to disclose to AIG HK such information, record and knowledge;
   (b) AIG HK or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests to underwrite and evaluate the Insured(s') health status in relation to the Claims therein and any matter 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;
   (c) the police that has any of the Insured(s') information to provide AIG HK with the information including but not limited to the police reports, witness statements, investigation and/or prosecution results;
   (d) airline(s) that has/have any of the Insured (s') information to provide AIG HK with the information including but not limited to flight details, booking details, irregularities reports and all information related to the Insured (s') bookings; and
   (e) any organization institution or individual that has any information, record or knowledge of the Insured(s') travel record to disclose to AIG HK such information, record and knowledge.

This authorization shall bind the Insured(s') / Claimant(s') successors and assigns and remain valid notwithstanding the Insured(s') / Claimant(s') death or incapacity in so far as legally permissible. A photocopy of this authorization shall be as valid as the original.

A. 於本索償申請表簽署之受保人/索償申請人謹此聲明盡其所知所信，上述所申報的一切資料均屬正確無誤，並無任何保留。

B. 就有關從此索償申請表所收集的個人資料，受保人/索償申請人同意及確認：
   (a) 除非於本表格上另有訂明，本表格所要求提供的個人資料(或於處理索償時所要求提供的個人資料)是供美亞保險香港有限公司("美亞保險") 處理保險索償申請的所需資料，若未能提供任何所需資料索償申請則可能不被處理；
   (b) 美亞保險可按列於其私隱政策的用途使用此表格所收集之個人資料，其用途包括:1)評核、調查、調整及就此索償申請作出決定; 2)管理受保人的保單(包括向再保險公司索取賠償) 及3)任何於本表格其它位置列明的目的；
   (c) 美亞保險亦可向以下類別的人士 (不論在香港或海外)轉交該些個人資料，作上述（b） 項所列明之用途:
      (i) 提供有關本人/吾等保單管理服務的第三者（包括再保險公司）；
      (ii) 財務機構，作處理此申請及收取保費；
      (iii) 公證人、調查員、第三者管理人、緊急支援服務提供者、法律服務提供者、零售商、醫療提供者、及交通工具機構，以處理索償事宜；
      (iv) 其它在任何國家之AIG集團之成員公司，作上述（b）項所有列明之用途；或
      (v) 其它於美亞保險私隱政策所列明的人士，作於私隱政策列明之用途。
   (d) 受保人/索償申請人可隨時致函到美亞保險香港有限公司之私隱事務主任(地址:香港郵政總局信箱456號或電郵：cs.hk@aig.com) 查閱、或要求修改其個人資料（美亞保險可就查閱及修改要求收取合理費用）。如對美亞保險提供的服務有任何意見，可按上述地址聯絡美亞保險。美亞保險私隱政策的全文載於www.aig.com.hk。

C. 受保人/索償申請人茲授權：
   (a) 任何知悉或擁有受保人之健康狀況及病歷或任何治療或諮詢記錄或資料及曾為或將為受保人診治之機構、組織或人士，向美亞保險透露有關資料及記錄；
   (b) 美亞保險或任何其認可之驗身醫生或化驗所，替受保人進行所需之醫療評估及測試，並對受保人之健康狀況進行審核及評估，作為處理本索償申請及其後與之有關的賠償事宜。此等化驗包括，但並不限於膽固醇及有關之血脂肪、糖尿病、肝或腎功能失常、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;
   (c) 警方向美亞保險提供有關受保人之任何資料包括但不限於警察報告、証人口供、調查及/或檢控結果;
   (d) 航空公司向美亞保險提供有關受保人之任何資料包括但不限於航班資料、訂位資料、違規報告及所有有關受保人之訂位資料;及
   (e) 任何知悉或擁有受保人之出入境資料紀錄之機構、組織或人士向美亞保險透露有關資料及紀錄。

此授權書不得徹回。在法律許可下，即使受保人/索償申請人死亡或喪失能力，此授權書仍然存有法律效力，而受保人/索償申請人之繼承人及轉讓人亦會受此授權書約束。此授權書之副本與正本均屬有效。

Name of Insured /Claimant (if applicable) 受保人/索償申請人(如適用)姓名	Signature of Insured/ Claimant (if applicable) (If the Insured is below the age of 18, the Insured's Parent/Legal Guardian should sign on his/her behalf)) 受保人/索償申請人(如適用)簽署(如受保人未滿18歲，則由其父母或合法監護人簽署)
Insured /Claimant's ID Card No./Passport No. 受保人/索償申請人身份證/護照號碼	Date 日期 DD 日 MM 月 YYYY 年
Name of Parent/Legal Guardian (English) (If the Insured is under the age of 18) 父母/合法監護人姓名(英文) (如受保人未滿18歲)	Signature of Parent/Legal Guardian (If the Insured is below the age of 18) 父母/合法監護人簽署 (如受保人未滿18歲)
Parent/Legal Guardian's ID Card No./Passport No. 父母/合法監護人身份證/護照號碼	Date 日期 DD 日 MM 月 YYYY 年

Producer's Information (if applicable)
保單經紀資料(如適用)

Name 名稱	Code 編號	Mobile Phone No. 手提電話號碼 Acknowledgement will be sent to this mobile phone number via SMS upon receipt of this form. 本公司將會在收到此索償申請表後發送確認短訊至此手提電話號碼。	Email Address 電郵地址