Accident & Health Insurance Claim Form
意外及醫療保險索償申請表

pa.claim.hk@aig.com | Enquiry: +852 3666 7090

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。

- Please notify us if you require to have the Certified True Copy ("CTC") of original medical receipts from us. CTC will be returned after claim is finalized. Original medical receipts will not be returned regardless you specify or not.
  如您需取回醫生的發票和收據核實副本，請知會本公司作申請，核實副本於完成此索償個案後發出。不論閣下是否有特別請求，正本文件也不將獲發還。
- 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) 2838 9916
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) 2838 9916
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)
Insured's HKID No/Passport No 受保人香港身份証/護照號碼	Name of Insured (English) 受保人姓名(英文)	Name of Insured (Chinese) 受保人姓名(中文)
Insured's Occupation 受保人職業	E-mail Address 電郵地址	
Mailing Address 通訊地址 This address is used for this claim only. Please contact us at cs.hk@aig.com for changes required in registered policy address. 此地址只適用於是次索償，如需更改保單登記地址，請電郵至cs.hk@aig.com與我們聯絡		Mobile Phone No. 手提電話號碼 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

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，根據美國法案Medicare, Medicaid & SCHIP Extension Act of 2007，需要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 Expenses 住院醫療費用
☐ Critical Illness 危疾
☐ Accidental Death & Permanent Disability 意外死亡及永久傷殘
☐ Hospital Income 住院現金
☐ Other, please specify 其他，請詳述： _____

Amount 索償金額	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 _____ Settlement Amount 賠償金額 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$ _____

Total receipts amount 收據總額	HK$

- To avoid double indemnity, you are required to notify us for total reimbursements received from us and other sources if the total amount of reimbursements received is greater than the actual medical expense spent.
- 當您從本公司及其他保險公司/第三方合共獲得的醫療費用賠償金額多於實際醫療費用時，請必須知會本公司，以避免雙重賠償。

Claim Amount for Hospital Income 住院現金索償詳情

Type (please tick) 類別 (請選擇) ☐ Private Hospital 私家醫院 ☐ Public Hospital 政府醫院 ☐ Waiving of medical charges for eligible persons 符合醫療費用豁免資格人士

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

(If the hospital did not charge daily room charge on discharge date, the day of discharge is not included in no. of room charge days.)
(如醫院在出院日沒有收取病房收費，出院日不包括在日數內。)

Daily ward room charge 病房每日收費 HK$ _____ X no. of days 日數 _____ Day(s) 日 = Room charges 病房收費 HK$ _____

Daily ward room charge 病房每日收費 HK$ _____ X no. of days 日數 _____ Day(s) 日 = Room charges 病房收費 HK$ _____

Total room charges 病房合共收費	HK$

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. 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. 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

☐ Faster Payment System (FPS) 快速支付系統 (「轉數快」) ****Only applicable for claims payment amount under HKD10,000. **只適用於不超過港幣10,000 元的索償支付金額之個案。**

或 or

☐ Direct credit to Hong Kong Bank Account (HKD account only) 支付到銀行帳戶 (只限港幣戶口)

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:
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.
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.
3. Please provide **One (1)** of the proxy (phone number /e-mail address/FPS ID) in below field.
4. Please provide **e-mail address** for sending Claim statement, otherwise the payment cannot proceed.

注意事項:
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. 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. 請於下面只提供 **一個** 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. 請提供 **電子郵件地址** 以發送賠償明細表，否則無法進行付款。

(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	FPS ID 快速支付系統識別碼
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

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:
1. Please provide a **copy of bank passbook or ATM card**, otherwise the payment cannot proceed.
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.
3. Please provide **e-mail address** for sending Claim statement, otherwise the payment cannot proceed.

注意事項:
1. 請提供 **銀行存摺 或 提款卡副本**，否則無法進行付款。
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. 請提供 **電子郵件地址** 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 ___ ___ ___ Branch Code 分行號碼 ___ ___ ___	Account Number 戶口號碼 ___ ___ ___ ___ ___ ___ ___ ___ ___
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

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 DD 日 / MM 月 / YYYY 年 / ☐ A.M. 上午 ☐ P.M. 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

Part of body affected 身體受傷部位	Nature of Injury (applicable for accident) (please tick) 受傷性質 (適用於意外) (請選擇) ☐ Sprain 扭傷 ☐ Fracture 骨折 ☐ Abrasion 磨損 ☐ Dislocation 脫臼 ☐ Whiplash 揮鞭式創傷 ☐ Contusion 撞傷 ☐ Laceration 割傷 ☐ Burns 燒傷 ☐ Strain 拉傷 ☐ Other, please specify 其他，請詳述：

INJURY CASE ONLY: Was the injury caused by an accident? 如屬受傷個案: 傷患是否由意外造成？ ☐ Yes 是 ☐ No 否

INJURY CASE ONLY: Where did the accident occur? Please provide the exact location/address.
如屬受傷個案: 意外在哪裡發生？請提供確實位置/地址

INJURY CASE ONLY: How did the accident that caused the injury occur?
如屬受傷個案: 導致傷患的意外是如何發生?

INJURY CASE ONLY: Was a third party involved in the accident? If so, please provide the details of the third party.*
如屬受傷個案: 意外中是否涉及第三方？如是，請提供第三方的詳細資料*

*We reserve our rights to recover any amounts paid to you from the third party. *我們保留向第三方追討支付給您款項的權利

In the case of sickness, what were the symptom(s) and when(by date) did the symptom(s) first appeared?
如屬疾病個案，請說明病徵及首次出現病徵的日期。

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
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？
Do you need to be hospitalized in the future? 你將來是否需要住院？ ☐ Yes 是 ☐ No 否	If yes, how long will the further medical treatment last? 如是，請提供住院計劃 (如何時，多久需住院，及持續多久？)

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？
☐ 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 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	☐ 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

(i) Can the treatment and medical test(s) be managed under an outpatient or day care setting?
是次治療和醫學檢查是否可以在門診或日間護理環境下處理？
☐ Yes 是　☐ No 否
If yes, please explain why hospital confinement was arranged. 若然可以，請解釋為何安排住院。

(ii) Did the Patient take any home leave during such hospitalization? 病人有否在住院期間請假外出？
☐ Yes 是　☐ No 否
If yes, please provide the date, time & reason(s) of the home leave taken. 如有，請列明外出之時間，日期及原因。

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 surgical procedure 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。

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

Section 5 – Declaration and Authorization　第五部份 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 (If Insured is below the age of 18) 父母/合法監護人姓名 (如受保人未滿18歲)	Signature of Parent/Legal Guardian (If 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

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