AIA International Limited
(Incorporated in Bermuda
with limited liability)

CRITICAL ILLNESS CLAIM FORM
危疾保障賠償申請表

Name of Employer / Group Policyholder
公司名稱 / 團體保單投保公司名稱 ______________________

Group Policy No.
團體保單號碼 ______________________

PART I (TO BE COMPLETED BY THE INSURED / CLAIMANT) 第一部份由受保人或申請人填寫

Amount of Assurance 保額	Name of Insured 受保人姓名	Age 年歲	This is a: 這次是： ☐ New Claim 首次索償 ☐ Further Claim 再次索償 ☐ Review 重批 / 覆核
	HKID Card No. 香港身份証號碼	Sex 性別	Contact Phone No. 聯絡電話號碼
Correspondence Address 聯絡地址			E-mail 電郵地址

NATURE OF CLAIM AND RELATED DETAILS 賠償性質及有關資料：

1. Name the critical illness you are claiming for. 申請賠償的危疾名稱	1.
2. Date of first consultation. 首次求診日期	2. MM / 月 DD / 日 YY / 年
3. Describe the symptoms from date of onset. 詳述病發日起所患之一切病徵	3.
4. The name, address and contact phone no. of the doctor you first consulted for this illness. 首次就此病而求診之醫生姓名、地址及聯絡電話	4.
5. How long have you been having these symptoms from the date of your first consultation? 閣下在首次求診日起，以上的病徵已存在多久？	5.
6. The name, address and contact phone no. of your regular doctor. 閣下慣常求診之醫生姓名、地址及聯絡電話	6.

RECORD OF MEDICAL CONSULTATION / HOSPITALIZATION 過往之求診及住院記錄：

7. Please give below the details of any doctor(s) who have been consulted in connection with illness.
請提供曾診治此病的其他醫生或專科醫生資料。

	Name 姓名	Address 地址	Date (MM / DD / YY) 求診日期 (月 / 日 / 年)
a.			
b.			
c.			

8. Please give below details of any hospitalization in connection with this illness.
請提供與此病有關之住院記錄。

	Name of Hospital 醫院名稱	Date of Admission (MM / DD / YY) 入院日期 (月 / 日 / 年)	Date of Discharge (MM / DD / YY) 出院日期 (月 / 日 / 年)
a.			
b.			
c.			

GENERAL 其他資料：

9. Has any of your blood relatives suffered from a similar or related illness? If “yes”, please state.
直系親屬中有否曾患有相同或有關之危疾，如“有”，請填寫下欄。

	Relationship of Relative 親屬關係	Nature of Illness 危疾類別	Date Illness Diagnosed (MM / DD / YY) 診斷日期 (月 / 日 / 年)
a.			
b.			
c.			

10. Are there any other illness/complaints treated for or suffered by you prior to this critical illness you are claiming for? If so, please give full details.
閣下在患有是次申請賠償之疾病前是否患有其它疾病，如“有”，請把有關資料詳細填報。

a.

b.

c.

11. Are you insured for similar benefits with any other Company? If “yes”, please state.
閣下是否在其它公司投保類似危疾保障？如“有”，請填寫下欄。

	Name of Insurer 投保公司名稱	Type / Amount of Benefit 投保類別 / 金額	Policy Number 保單號碼
a.			
b.			
c.			

DECLARATION AND AUTHORIZATION 聲明及授權

I / We declare that the answers given in this form are true and complete.
本人／我們聲明本申請表每一項答案為完全和真確。

I confirm that I have read and understood the AIA Personal Information Collection Statement ("AIA PIC"). On behalf of myself and my covered dependents (if applicable), I declare and agree that any personal data and other information relating to me or my covered dependents (if any) or my / our policy(ies) or investments contained in this enrollment form or collected, obtained, compiled or held by AIA by any means from time to time may be collected and utilized in accordance with the AIA PIC. I acknowledge and consent to the transfer of my personal data (and that of my covered dependents, if any) outside of Hong Kong for the purposes and to the types of transferee as set out in the AIA PIC.

The updated version of AIA PIC is available for download from its website: www.aia.com.hk, and is made available upon request.

I / We also hereby irrevocably authorize:

a. any organization, institution, or individual that has any record or knowledge of my / the insured's employment, sick leave records, accident or loss details (of any sorts), health and medical history or any treatment or advice that has been or may hereafter be consulted to disclose to AIA such information. This authorization shall bind my / the insured's successors and assignees and remain valid notwithstanding my / the insured's death or incapacity in so far as legally possible. A photocopy of this authorization shall be as valid as the original.

b. AIA 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 health status in relation to this application and any claim arising therefrom. These tests may include, but are not limited to, tests of cholesterol and related blood lipids, diabetes, liver or kidney disorders, acquired immune deficiency syndrome (AIDS), infection by any human immunodeficiency virus (HIV), immune disorder or the presence of medications, drugs, nicotine or their metabolites

I / We hereby agree with and authorize AIA to deduct the reimbursement of claims payment in the event that I, and / or my dependents, have any shortfall amount, for whatever reason, due to AIA.

本人確認本人已閱讀及明白AIA個人資料收集聲明(「AIA個人資料收集聲明」)。本人及本人謹代表的受保家屬(如適用)等聲明及同意在本申請所載或AIA不時以任何方法收集所得、編製或持有的任何個人資料及關於本人或本人的受保家屬(如有)或本人的保單或投資的其他資料，可根據AIA個人資料收集聲明收集及使用。本人知悉及同意就AIA個人資料收集聲明所述目的轉讓本人(和本人的受保家屬(如有))的個人資料至香港境外予AIA個人資料收集聲明所載的資料承讓人。

AIA個人資料收集聲明的最新版本可於AIA網址下載：www.aia.com.hk，及可向AIA索取。

本人／我們茲授權：

a. 任何知悉或擁有本人／受保人之工作、病假記錄、意外或損失(任何類別)之詳情、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／受保人診治之機構、組織或人仕、向友邦保險透露有關資料，不得撤回。即使本人／受保人死亡或喪失能力，此授權書仍然存有法律效力，而本人／受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. 友邦保險或任何其認可之驗身醫生或化驗所，本人／受保人進行所需之醫療評估及測試，並對本人／受保人之健康狀況進行審核及評什，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、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、尼古丁及其代謝品含量等化驗。

本人／我們同意及授權友邦保險於賠償金額上扣除本人及／或本人家屬尚未清還友邦保險之任何欠款。

Authorized Signature
認可簽署

Name :
姓名 : ____________________

Tel. No. :
電話號碼 : ____________________

Date :
日期 : ____________________

Signature of Insured / Claimant
受保人／申請人簽署

Name :
姓名 : ____________________

HKID Card No. :
香港身份証號碼 : ____________________

Date :
日期 : ____________________

Tel. No. :
電話號碼 : ____________________

Company Chop
公司印鑑

Remarks : "AIA" refers to AIA International Limited (incorporated in Bermuda with limited liability)
備註 :「友邦保險」是指友邦保險 (國際) 有限公司 (於百慕達註冊成立之有限公司)