AIA International Limited
(Incorporated in Bermuda
with limited liability)

LONG TERM DISABILITY CLAIM FORM
長期不能工作賠償申請書

This printed form is forwarded on receipt of notice of a disability and its being sent is in no way an admission of claim. It and the Attending Physician's Statement must be completed and RETURNED WITHIN FIFTEEN DAYS AFTER THE EXPIRY OF YOUR WAITING PERIOD. In addition, the Employer's Statement will be required in the case of all initial claims for any period of disability.
本表格只表示接受申請而並非已核准賠償。又本表格及主治醫生之報告書須於守候期後十五日內遞交予友邦保險。倘屬第一次申請賠償，則需連同僱主陳述書一併遞交。
* No fees, commissions or charges of whatever nature are payable to agents or employees of AIA in respect of this claim.
* 友邦保險任何僱員或營業員均不得收取任何費用。
** Please provide contact information. It will be updated to our record in accordance with the arrangement with your employer.
** 請提供聯絡資料，我們將根據與您的僱主所訂下的安排更新該等資料。

PART I (to be completed by Insured) 第一部份(由受保人填寫)

Policy No.保單號碼 :		Claim No.賠償號碼 :	
Name of Group Policyholder: 團體保單投保公司名稱	Name: 姓名 HKID Card No.: 香港身份証號碼	Date of Birth: 出生日期	Agent / Agency Name: 營業員 / 營業組別名稱
Home Address: 住址		Business Tel No.: 辦公室電話號碼	Res. Tel. No.: 住宅電話號碼
E-mail Address:** 電郵地址**		Mobile No.** 手提電話號碼**	

Question	Answer
1. Present Occupation (if more than one, state all) 現職(倘有兼職請列明)	1.
2. Exact nature of occupational duties: 職位及職責	2.
3. Name and Address of business or employer: 公司或僱主名稱及地址	3.
4. Was your disability due to accident? If so, 是否因意外而致不能工作？倘是，	4. ☐ Yes 是 ☐ No 否
a. Was the accident in any way related to your job? If so, give details. 是否因工作引起？倘是，請詳述。	a. ☐ Yes 是 ☐ No 否
b. Give the date and time of the accident. 遭受意外傷害之日期及時間。	b.
c. State how, when and where it happened. 意外在何時、何地及如何發生？	c.
d. Describe in detail the injuries sustained, indicating the part of the body injured and the type of injury (e.g. fracture, cut, bruise etc.) 詳述受傷細節、受傷之部位及傷勢 (例如骨折、斷肢及瘀傷)。	d.
e. Give the name and address of the first doctor you visited after your accident. 受傷後第一位診治醫生之姓名及地址。	e.
5. Was your disability due to illness? If so, 是否因病不能工作？倘是，	5. ☐ Yes 是 ☐ No 否
a. What was the illness? 所患何病？	a.
b. Give a brief description of your symptoms. 病徵如何？	b.
c. Approximately when did you first have these? 何時發覺有此病徵？	c.
d. When did you first visit a doctor for these and what was his name and address? 首次求診的日期及診治醫生的姓名及地址。	d.
6. Were you hospitalised during your disability? If so, please attach your hospital bill and give 不能工作時是否住院？倘是，請呈交醫院收據及列明	6. ☐ Yes 是 ☐ No 否
a. The name of the hospital 醫院名稱	a.
b. The dates of your initial hospitalisation 首次住院日期	b.
c. The dates of any subsequent hospitalisation 其後住院日期	c.
7. Other than the doctor you first consulted for this injury or illness, what other doctors or hospitals have you consulted in the last two years for this or any other illness or injury? Please give names, addresses, dates consulted and reason. 此次之傷病除第一位診治醫生外，過去兩年有否因同樣傷病或其他傷病向其他醫生或醫院就醫？倘有， 請詳列醫生及醫院名稱、地址、就醫日期及原因。	7.
8. On what date did you last work prior to disability? 最後之工作日期	8.

Question	Answer
9. Please give the following information about your total earned income from all your jobs prior to disablement. 請詳列不能工作前，每年之入息總數。 a. Your monthly basic salary. 每月底薪 b. The total amount of any commission paid to you in the previous twelve months. 過去十二個月所獲之佣金總數 c. The year end bonus paid to you at each of the previous two year ends. 過去兩年，每年所獲之年底花紅	9. a. b. c.
In addition, if you are self-employed, please give: 倘屬自僱身份，請提供： d. The amount of director's Fees paid to you in the previous twelve months. 過去十二個月，所獲之董事費 e. Your share of the pre-tax profits your company made (prior to dividends) in the previous twelve months. 過去十二個月於公司未派息及未繳稅之利潤中所獲之純利	d. e.
10. If you have returned to work. 如已恢復工作 a. On what date did you return to work? 何日恢復工作？ b. Did you return to your original occupation and your original duties? If not, please give details: 是否復任原有職業？如否，請詳述。 c. Since you return to work, is your salary lower than it was prior to your disability? If so, 恢復工作後，薪金是否較前低？倘是，請詳述 (i) What's your current salary? 現時之薪金 (ii) Is the drop in salary due to the after-effects of your previous illness or accident? 薪金之降低是否因此次之傷、病所致？	10. a. b. ☐ Yes 是 ☐ No 否 c. ☐ Yes 是 ☐ No 否 (i) (ii) ☐ Yes 是 ☐ No 否
11. If you have not yet returned to work. 倘仍未能恢復工作 a. What is preventing you from working at the moment? e.g. paralysis, cannot stand for long, cannot walk. 何以現時仍未能工作？例如：癱瘓、不能久站、不能步行 b. Give the date on which you expect to work? 預料何日可恢復工作？	11. a. b.
12. Has your employer continued to pay the whole or part of your salary since you ceased work? If so, how much has been paid to you each month throughout that period? 自你停止工作後，僱主有否繼續支付你全部或部份薪金？如有，你於此期間內，每月所得之薪金若干？	12. ☐ Yes 是 ☐ No 否

13. Are you at the moment insured against disability by your employer or under any insurance policy? If so, please give:
僱主或你本人有否為你投保不能工作之保險或任何保險？如有，請填報下列各項：

Name of Insurance Company 保險公司名稱	Policy No. 保單號碼	Type of Insurance 保險計劃	Amount of Benefits 保險利益	Date Insurance Effected 保險生效日

Question	Answer
14. Have you made or do you intend to make any claim against any of the policies listed above? 你有否或打算就上述保單申請賠償？ If so, has it been honoured? 倘是，是否獲准？	14. ☐ Yes 是 ☐ No 否 ☐ Yes 是 ☐ No 否
15. Have you received or do you believe you are entitlied to receive payments, other than in the form of salary? 除薪金外，你有否已收取或你是否相信你應收取來自以下之款項？ a. from your employer 由你僱主給予 b. from your insurance company, or 由保險公司給予 c. from any other source to compensate you for your disability or for the cause of your disability? 由其他機構因你不能工作而給予之補償？ If so, please give details. 倘有，請詳述	15. a. ☐ Yes 是 ☐ No 否 b. ☐ Yes 是 ☐ No 否 c. ☐ Yes 是 ☐ No 否
16. Have you arranged to have your employer complete the Employer's statement? 你有否請僱主填寫僱主陳述書？ Or do you wish AIA to write to your employer directly? 或擬請友邦保險逕函你僱主查詢？	16. ☐ Yes 是 ☐ No 否 ☐ Yes 是 ☐ No 否

Declaration and Authorization

I / We hereby irrevocably authorize:

(i) any organization, institution or individual that has any record or knowledge of my / the insured(s)'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)'s successors and assignees and remain valid notwithstanding my / the insured(s)'s death or incapacity in so far as legally possible. A photocopy of the authorization shall be as valid as the original.

(ii) 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)'s health status in relation to this application and any claim arising therefrom. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, acquired immue 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.

聲明及授權

本人／我們茲授權：

(i) 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、組織或人士，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。

(ii) 友邦保險或任何其認可之驗身醫生或化驗所，替本人／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、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、尼古丁及其代謝物之含量等化驗。

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。

DIRECT PROMOTIONAL AND MARKETING MATERIALS

I / We confirm that I / we have read and understood the AIA Personal Information Collection Statement ("AIA PIC"). I / We agree to the provision and use of my / our personal data for direct marketing purposes in accordance with the AIA PIC. I / We acknowledge and consent to the transfer of my / our personal data outside of Hong Kong (for policies issued in Hong Kong) or Macau (for policies issued in Macau) for direct marketing purposes and to the types of transferee as set out in the AIA PIC.

☐ Please tick the box on the left if you do not agree with the provision, use and transfer of your personal data for direct marketing purposes in accordance with the AIA PIC.

宣傳及市場推廣資料

本人/ 我們現確定本人/ 我們已閱讀及明白AIA個人資料收集聲明（「AIA個人資料收集聲明」）。本人/ 我們同意根據AIA個人資料收集聲明，提供本人/ 我們的個人資料用作直銷推廣用途。

本人 / 我們確認及贊同把本人/ 我們的個人資料轉移至香港(如保單在香港繕發)或澳門(如保單在澳門繕發)境外作直銷推廣用途，並把相關的個人資料轉移至AIA個人資料收集聲明中列明的資料承讓人。

☐ 倘若不同意根據AIA個人資料收集聲明，提供、使用及轉移個人資料用作直銷推廣用途，請在上列☐一欄劃上✓。

PERSONAL DATA COLLECTION AND USE

I / We confirm that I / we have read and understood the AIA Personal Information Collection Statement ("AIA PIC"). I / We declare and agree that any personal data and other information relating to me / us or my / our policy(ies) or investments contained in this claim 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 / We acknowledge and consent to the transfer of my / our personal data outside of Hong Kong (for policies issued in Hong Kong) or Macau (for policies issued in Macau), as the case may be, 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.

個人資料收集及使用

本人/我們確認本人/我們已閱讀及明白AIA個人資料收集聲明（「AIA個人資料收集聲明」）。本人/我們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/我們或本人/我們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/我們知悉及同意就AIA個人資料收集聲明所述目的視乎情況轉讓本人/我們的個人資料至香港(如保單在香港繕發)或澳門(如保單在澳門繕發)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。

Signature of Witness
見証人簽名
Name:
姓名
Address:
住址:

Signature of Insured
受保人簽名

Date:
日期

In the event of the insured being unable to sign the form, it should be filled up and siqned by a near relative or other responsible person in charge of the insured during his disability.
倘受保人不能親自填寫表格，可由其近親或有關之負責人代為填報及簽名。

PART II EMPLOYER'S STATEMENT FOR LONG TERM DISABILITY CLAIM
第二部份 僱主陳述書（長期不能工作賠償申請書）

Employee's Name: 僱員姓名	HKID Card No.: 香港身份証號碼

Question	Answer
1. a. In what position is the insured employed by you? 受保人的職位 b. What are his / her duties? 受保人的職責	1. a. b.
2. On what date did the insured last work prior to his / her disability? 請病假前一日之日期	2.
3. What was his / her monthly earned income from your company prior to disablement? 不能工作前之每月入息 a. Basic Salary 底薪 b. Other Benefits 其他利益	3. a. b.
4. Do you pay your employees a Year End Bonus? If so how many months? 有否年終花紅頒發？ 如有，請說明若干月？	4. ☐ Yes 是 ☐ No 否
5. Have you paid his / her salary or part of his / her salary since his / her disablement commenced? If so, 不能工作後有否支付全薪或部份薪金？如有， a. How much has been paid to him / her each month since? 每月支付多少？ b. How long will you continue to pay this? 擬繼續每月支付多久？	5. ☐ Yes 是 ☐ No 否 a. b.
6. Does your company have insurance to cover the disability of your employees? If so, please give details. 有否為僱員購買不能工作之保險？ 如有，請詳述。	6. ☐ Yes 是 ☐ No 否
7. Do you believe that you are liable to pay Workmen's Compensation in respect of this disability? 你是否應負不能工作的勞工保險賠償之責？	7. ☐ Yes 是 ☐ No 否
8. Has the insured returned to work? If so, 受保人是否已恢復工作？倘是， a. On what date? 何日恢復工作？ b. If he / she is not able to do all his/her original duties, what duties can he / she not do and why? 如不能如前工作，不能做之工作及原因為何？ c. By what amount has his / her salary reduced as a result of item b? 因b項情況，受保人之薪金被減若干？	8. ☐ Yes 是 ☐ No 否 a. b. c.
9. Have you terminated the insured's employment? If so, 你有否將受保人解僱？倘有， a. On what date? 何日解僱？ b. For what reason? 解僱原因為何？	9. ☐ Yes 是 ☐ No 否 a. b.

I hereby certify that the above information is given to the best of my knowledge and belief.
我承認以上乃就本人所知據實填報。

Signed
簽署：________________

Name
姓名：________________

Date
日期：________________

Position in Company
公司職位：________________

Company Chop
公司印鑑：________________

Tel. No.
電話號碼：________________

PART III ATTENDING PHYSICIAN'S STATEMENT FOR LONG TERM DISABILITY CLAIM

No claim can be admitted unless the Attending Physician's Statement below is furnished, at the expense of the insured, by a duly qualified and registered medical practitioner.

Patient's Name:	Age:	HKID Card No.:
1. a. On what date did the patient first consult you for his/her current disability?	1. a.	
b. Was the patient referred by another doctor? If so, please indicate his / her name and address.	b. ☐ Yes ☐ No	
c. Had the patient consulted you for any other reason in the two years prior to his/her current disability? If so, please give the dates of these consultations and appropriate diagnoses.	c. ☐ Yes ☐ No	
d. To your knowledge, has the patient ever suffered from any other significant disorder? If so, please indicate the diagnosis and if known to you the names of the doctors consulted and approximate dates.	d. ☐ Yes ☐ No	
2. If disability was due to accident, describe and locate. a. Cause, character and extent of injures and state whether there was any external and visible evidence of injury at first consultation.	2. a.	
b. Present condition of the injury.	b.	
c. Names and addresses of other Physicians who treated the patient for the same injury: Name Address Treatment		
d. Was healing complicated? If so, state why and describe any special treatment given.	d. ☐ Yes ☐ No	
e. Give details of any circumstances, such as intoxication, physican defects or medical history which may have contributed to the accident.	e.	
3. If disability was due to illness: a. Of what symptoms did the patient complain when he / she first saw you for this illness?	3. a.	
b. (i) According to the patient, how long had he / she been experiencing these symptoms? (ii) How long do you feel the symptoms had lasted?	b. (i) (ii)	
c. Had the patient previously seen any other doctor on account of these symptoms? If so, please give details.	c. ☐ Yes ☐ No	
d. (i) What was your diagnosis? (ii) Did you inform the patient of your diagnosis? If so, when did you do so?	d. (i) (ii) ☐ Yes ☐ No	

4. Please give details of the investigations carried out in connection with the illness or injury and their dates.	4.
5. Please give details of any medical or surgical treatment given by you or at your request in respect of the illness or injury: Date Type of Treatment	
6. Was the patient hospitalised in the course of this disability? If so, please state: Date Admitted Admission No. Date Discharged Name of Hospital Name of Doctor	
7. If the patient is female: a. Was she pregnant at any time furring her disability? b. Did her pregnancy directly or indirectly cause or lengthen the period of her disability in any way? If so, please give details.	7. a. ☐ Yes ☐ No b.
8˙ On what date did you personally last see the patient?	8.
9. Do you feel that the patient can perform all the duties of his / her regular occupation? If not, please state: a. Whether he / she is partially or totally disabled?	9. a.
b. The cause of his / her continuing disability. Please be as detailed as possible.	b.
10. Please give details of any other mental or physical disorders, habits or other factors, which in your opinion may have caused or lengthened the Insured's disability.	10.

I hereby certify that I have personally examined and treated the Insured in connection to the above disability and that the facts as given above present my opinion of his / her condition.

Signed: ______________________ Name of Physician: ______________________

Date: ______________________ Address: ______________________

Qualification: ______________________ Tel. No. ______________________

AIA address in HK: AIA International Limited, AIA Corporate Solutions, 12/F, AIA Financial Centre, 712 Prince Edward Road East, Kowloon, Hong Kong
友邦香港辦事處：香港九龍太子道東712號友邦九龍金融中心12樓友邦保險企業業務
AIA address in Macau: AIA International Limited, AIA Corporate Solutions, 1903, AIA Tower, Nos. 251A-301 Avenida Commercial de Macau, Macau
澳門友邦保險辦事處：澳門商業大馬路251A－301號友邦廣場1903室友邦保險企業業務

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)