AIA International Limited
(Incorporated in Bermuda
with limited liability)

GROUP TOTAL & PERMANENT DISABILITY CLAIM FORM
完全及永久喪失工作能力賠償申請書

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

* 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。

Policy No.: 保單號碼	Name of Insured: 受保人姓名 HKID Card No.: 香港身份証號碼	Age: 年歲 Sex: 性別	E-mail Address:* 電郵地址 * Mobile Tel No.:* 手提電話號碼 *

EMPLOYMENT PARTICULARS:
就業詳情

1. Occupation (if more than one, state all) and exact nature of occupational duties before disability 現職（倘有兼職請列明）職位及職責	1.
2. Name and address of business or employer 公司或僱主名稱及地址	2.
3. Did you file a sick leave certificate with your employer? 曾否向僱主遞交病假證明書	3. Yes 是 ☐ No 否 ☐
4. Date you last worked: 最後工作日期	4. ___ ___ ___ MM / 月 DD / 日 YY / 年
5. Date you returned to work, (if no, then give expected date of return) 何時恢復工作（如否，祈望何時可恢復工作）	5. ___ ___ ___ MM / 月 DD / 日 YY / 年

PLEASE COMPLETE IF DISABILITY WAS DUE TO ACCIDENT:
因意外而導致喪失工作能力適用

6. a) Date and time of accident: 意外日期及時間	6. a ___ ___ ___ MM / 月 DD / 日 YY / 年 _____ am / pm 上午 / 下午
b) Where and how did it happen? 意外地點及經過	6. b
c) Part of body injured and type of injury. 受傷部位及傷勢	6. c

PLEASE COMPLETE IF DISABILITY WAS DUE TO ILLNESS:
因病而導致喪失工作能力適用

7. a) Indicate the illness and give a brief description of symptoms. 指出所患疾病及描述其病徵	7. a
b) How long had he / she been having these symptoms prior to the first consultation? 受保人在首次就診前該等病徵已存在多久	7. b
c) Give details of consultation. 診治詳情 i) The doctor first consulted for this illness. 首次就診的醫生資料	7. c Date 求診日期 / Name(s) and Address(s) of Doctor(s) / Hospital(s) 醫生 / 醫院名稱及地址 i)
ii) The doctor who referred the insured to hospital. 建議入院的醫生資料	ii)

8. DETAILS OF PHYSICIAN(S) CONSULTED OR HOSPITAL(S) ADMITTED FOR CURRENT DISABILITY
曾就診之醫生姓名或醫院詳情

	Name(s) 姓名	Address(es) 地址	Admission No. (s) 求診或住院號碼	Admission Date(s) 求診或住院日期
(a)				
(b)				
(c)				
(d)				

9. ARE YOU CURRENTLY INSURED FOR DISABILITY BENEFIT WITH ANY OTHER INSURANCE COMPANY
(If "YES", please provide the following information)
是否受保於其他保險公司（如“是”，請提供以下資料）

	Name of Insurance Company 保險公司名稱	Amount of Life Insurance 保額	Rider Attached 附加契約	Policy Number 保單號碼
(a)				
(b)				
(c)				
(d)				

DECLARATION AND AUTHORIZATION 聲明及授權

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.

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.

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.

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。

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 ✓。

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 見証人簽署	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 :	Name : 姓名 :	HKID Card No. : 香港身份証號碼 :
Date : 日期 :		Date : 日期 :	

Remark: This declaration and authorization must be signed by the insured. If the insured is a minor, the insured's parent / legal guardian can sign on his / her behalf.
註解：此聲明及授權書必須由受保人簽署，若受保人為小童，則可由其家長／合法監護人簽署。

Please complete if the signature is not given by the insured.
若簽署者非受保人，請填寫此欄

Name (in block letter) _____ Relationship to insured _____
姓名（正楷書寫） 與受保人之關係

PART II (TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SURGEON AT THE CLAIMANT'S OWN EXPENSES)
第二部份由受保人自費由主診醫生或手術醫生填寫

Name of Patient: **ID Card / Passport No:**
病者姓名 : _____ **身份證 / 護照號碼 :** _____

(A)HISTORY & DIAGNOSIS 病歷及診斷

1. The date when symptoms first appeared or accident happened 病徵首次出現 / 意外發生日期 MM月 / DD日 / YYYY年	6. The final diagnosis of the condition and its complications 最後診斷結果及其併發症
2. Symptoms and complaints presented by the patient 病者主訴之病徵或徵狀	7. The academic qualification, qualified knowledge and training asdeclared by the patient 病者所申報之學歷、認可知識及訓練
3. The date of first consultation 首次求診日期 MM月 / DD日 / YYYY年	8. Patient's occupation (if more than one, state all) and exact nature ofoccupational duties before disability. 病者之現職 (倘有兼職請列明) 職位及職責。
4. Clinical and physical findings during first consultation 有關疾病 / 意外之初次診斷結果	9. The date the patient was first absent from work due to the condition. 病者首次就有關疾病 / 意外停止工作之日期。
5. The date when the diagnosis was first given 首次診斷日期 MM月 / DD日 / YYYY年	10.Has patient ever had same or similar condition? If so, please state whenand give details. 病者是否有類同之病歷？ 如 " 有 "，請說明何時及詳述細節。

11.Details of consultations and treatment rendered by you / hospital 由閣下 / 貴院提供之治療詳情：

Date / Period 日期 / 時期	Details of Treatment 治療詳情	Investigation / Special Procedures 檢驗 / 特殊醫療程序
MM月 / DD日 / YYYY年		

12.Name and address of other doctors / hospitals attended for treatment of this condition 病者就有關疾病 / 意外曾求診之醫生姓名及地址

Date of Treatment 治療日期	Physician / Hospital attended 求診醫生姓名 / 醫院名稱	Address 地址
MM月 / DD日 / YYYY年		

(B)CURRENT HEALTH CONDITIONS OF THE PATIENT 病者現時之健康狀況

1. Progress of recovery 康復進展

☐ Recovered 已完全康復 ☐ Improving 康復中 ☐ Static 情況穩定 ☐ Retrogressed 情況惡化

Remarks 註 :

2. Current state of mobility 日常活動概況
Give name of hospital and the period of hospital confinement, if any. 如需住院，請提供醫院名稱及住院日期。

☐ Ambulatory 行動自如 ☐ Home confined 需留在家中休息 ☐ Bed confined 需臥床休息 ☐ Hospital confined 需留院治療

Remarks 註 :

3. Please describe the current physical impairment.
請詳述病者現時之身體缺陷 / 損害情況。

4. Can the patient perform the right listed “Activities of Daily Living” without the use of mechanical equipment, special devices or other aids andadaptations?
按日常生活活動評估，病者在不受輔助下，可否完成下列的事項？

Transfer (to get in bed and out of bed or chair) 上下床或從椅子坐起 :	☐ can 可以	☐ cannot 不可以
Mobility 行動：	☐ can 可以	☐ cannot 不可以
Dressing 穿衣：	☐ can 可以	☐ cannot 不可以
Bathing & Washing 洗澡及梳洗：	☐ can 可以	☐ cannot 不可以
Eating 進食：	☐ can 可以	☐ cannot 不可以
Toileting 如廁：	☐ can 可以	☐ cannot 不可以

Remarks 註 :

5. With the current health condition of the patient in mind, what would you rate the present working capacity of the patient?
就病者現時之健康狀況而言，請評估其工作能力。

☐ No limitation of functional capacity, capable of heavy work without restrictions
能夠從事任何體力勞動工作

☐ Capable of medium manual activity
能夠從事中度體力勞動工作

☐ Slight limitation of functional capacity, capable of light work
只可從事輕度體力勞動工作

☐ Moderate limitation of functional capacity, capable of clerical / administrative activity
只可從事非體力勞動或文書工作

☐ Severe limitation of functional capacity, incapable of minimum activity
不可從事任何體力勞動甚或文書工作

Remarks 註 :

6. Please describe the current mental impairment of the patient (if normal, please go to Part C)
請詳述病者現時之精神缺陷 / 損害程度 (如精神狀況良好，請填寫 C 部份)

7. With the current mental status of the patient as described above, what would you rate the present ability for interpersonal relations andcommunication of the patient?
就病者現時之精神狀況而言，請評估其社交活動及溝通能力。

☐ Able to engage in all interpersonal relations and communication (without limitations)
社交活動及溝通能力均為完全正常

☐ Able to engage in most interpersonal relations and communication (slight limitations)
能應付大部份社交活動及與人溝通

☐ Able to engage in only limited interpersonal relations and communication (moderate limitations)
只能有限度地參加社交活動及與人溝通

☐ Unable to engage in interpersonal relations and communication (marked limitations)
嚴重缺乏社交活動及溝通能力

☐ Has significant loss of psychological, physiological, personal and social adjustment (severe limitations)
嚴重缺乏心理、生理、個人及社會適應能力

Remarks 註 :

(C)PROGNOSIS & REHABILITATION 進展及康復

1. Is the patient now totally disabled? 病者現時是否完全喪失工作能力？

In terms of his / her own job: 根據病者本身之工作或職業而言： ☐ Yes 是 ☐ No 否	In terms of any other jobs: 就從事或參與其他工作或職業而言： ☐ Yes 是 ☐ No 否

2. According to the patient's academic qualification, qualified knowledge and training, what duties of the patient's job is he / she incapable ofperforming?
根據病者申報之學歷、認可知識及訓練，請評估病者能夠從事之工作或職業。

☐ Capable of performing any kind of work and duties
能夠從事任何工作或職業

☐ Incapable of performing any kind of work and duties
不能從事或參與任何類型的工作或職業

☐ Capable of performing his / her own duties and occupation only
只能從事其本身之工作或職業

☐ Remarks 註 :

3. Do you expect a fundamental or marked change of this present condition in the future? ☐ Yes 是 ☐ No 否
閣下認為病者之狀況會否有基本 / 明顯的改善？

4. If yes, how long do you expect the patient will take to perform duties?
如 " 會 "，病者於何時才能重新工作？

In terms of own job: 根據病者本身之工作或職業而言：	In terms of any other jobs: 就其他工作或職業而言：
☐ Within 1 Mth 一個月內	☐ Within 1 Mth 一個月內
☐ 1-3 Mths 一至三個月內	☐ 1-3 Mths 一至三個月內
☐ 3-6 Mths 三至六個月內	☐ 3-6 Mths 三至六個月內
☐ 6-12 Mths 六至十二個月內	☐ 6-12 Mths 六至十二個月內
☐ >12Mths 多於十二個月	☐ >12Mths 多於十二個月
☐ Never 永不	☐ Never 永不
Remarks 註 :	Remarks 註 :

5. If no, please explain. 如 " 不會 "，請詳述。

6. Please state any further treatment / rehabilitation plan.
請說明任何進一步之治療及康復計劃。

(D)MISCELLANEOUS 其他

If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.
請提供其他有助審核本索償個案之資料。

I / We hereby declare that the information given on this form is true and complete to the best of my / our knowledge and belief.
本人 / 我們現聲明此申請書上所填資料皆為本人 / 我們所知及所信之事實及其全部。

PERSONAL DATA COLLECTION AND USE

PLEASE READ THE AIA PERSONAL INFORMATION COLLECTION STATEMENT ("AIA PIC") BEFORE YOU SIGN THIS CERTIFICATE. IF THE AIA PIC STATEMENT IS NOT ATTACHED, YOU CAN ASK FOR A COPY FROM US. Also, the updated version of AIA PIC is available for download from its website: www.aia.com.hk.

All the personal data and other information contained in this Confidential Medical Certificate will be used by us for the processing of the Insured's claim(s), and will also be utilized in accordance with AIA PIC. By asking you to fill in this Certificate, the Insured / Owner has given you the express consent to release his / her personal data and other information to our Company.

個人資料收集及使用

簽署此醫生報告前，請先閱讀 AIA 個人資料收集聲明。如 AIA 個人資料收集聲明未有隨附於本醫生報告，閣下可向我們索取複印本一份。AIA 個人資料收集聲明的最新版本亦可於以下網址下載 : www.aia.com.hk。

所有個人及其他於此醫生報告收集所得的任何資料將會被我們用作處理受保人之索償申請，我們亦可根據 AIA 個人資料收集聲明使用該些資料。向閣下提出要求填寫此醫生報告即表示受保人 / 保單持有人已授權閣下可於此報告透露他 / 她的個人資料及其他資料給我們。

Name of Doctor 醫生姓名 :	Signature 簽署 :
Qualification 醫學資格 :	Date 日期 :
Contact Telephone No. 聯絡電話 :	Official Stamp 蓋印 :
Address 地址 :	