Assicurazioni Generali S.p.A.
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1111 King's Road,
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T +852 2521 0707
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info@generali.com.hk
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Medical Claims Department
Member Service Hotline +852 3187 6831
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medicalcs@generali.com.hk

忠意保險有限公司
香港分行
香港英皇道1111號
太古城中心一期21樓
電話 +852 2521 0707
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醫療保險賠償部
會員服務熱線 +852 3187 6831
傳真號碼:+852 2387 6831
medicalcs@generali.com.hk

☐ Please return original receipt / cheque to the following address.
請退回正本單據/支票到以下地址
Address 地址: ____
____

HOSPITALIZATION / SURGICAL CLAIM FORM
住院 / 手術賠償申請表

PART A – Member Information – (to be completed by the insured member)
甲項 – 會員資料(由受保會員填寫)

Policy No. 保單號碼 :	Policy Holder / Company Name 保單持有人 / 公司名稱 :		
Member No. 會員號碼	Mobile No. : 手提電話:	Patient Name : 病者姓名:	Patient's Date of Birth (DD/MM/YYYY) 病者出生日期 (日/月/年)

Will you claim other insurance/compensation for this hospitalization/surgery? * Specify the Policy No. if it is insured by Generali Hong Kong Branch
此次住院/手術是否獲得其他保險金或補償金? * 如屬於忠意保險 香港分公司的醫療保單, 請提供保單號碼, 我們將一併處理。

□ No 否 □ Yes, Name of Insurance Company/Type of Compensation: 是, 保險公司名稱/補償金類別:____________________________

* Other Generali Medical Policy No.: / 其他忠意醫療保單號碼: ____________________________

□ For claim that is not fully reimbursed, please return the original receipt(s) for second claim submission.
如理賠申請未能獲全數賠款，請退回單據正本 ，以便申請其他理賠。

Has the patient had any prior treatment for this condition?
病者曾否在同一病況下就醫或治療?

□ No 否 □ Yes, Please state date: 是, 請填寫日期: ____________________________

If hospitalization was the result of an accident, please give date and a brief description of the accident:
如因意外受傷而入院, 請略述其發生之日期、地點及情況:

□ Work related 與工作有關 □ Non-work related 與工作無關 ____________________________

Notes for filing a claim:

1. Part A should be completed by the insured employee/member while Part B by Attending Physician.
2. Original bills and receipts must be attached showing the date of treatment, patient's name, diagnosis and the Attending Physician's stamp and signature. Please request Hospital to provide the itemized details and charges breakdown for laboratory, medication, treatment treatment/procedure.
3. Referral must be attached for specialist consultation.
4. For hospital claim, claim form must be sent to Claims Department within 90 days after discharge.
5. Original bills or receipts will not be returned (unless clearly stated). Please make copy as required.
6. If the hospitalization was made outside HKSAR, please specify the name of country and provide claim supporting document in English or Chinese.
7. If the hospitalization was made in Hospital Authority Hospital, please attached with the Discharge Summary for provision of diagnosis and surgery information.
8. Incomplete form or omission of required information may cause delay in processing.

申請賠償須知:

1. 此表格之甲項須由僱員/會員填報，而乙項則須由主診醫生填報。
2. 必須附上正本單據及收條，單據及收條須包括診治日期、病者姓名、診斷以及主診醫生蓋章及簽署。請要求院方提供化驗、藥物及其他治療的詳細資料及收費。
3. 專科賠償，必須附上轉介推薦書。
4. 住院賠償申請必須在出院後 90 日內交回賠償部。
5. 所有正本單據及收條俱不會發還(除非清楚註明)，請自行影印副本。
6. 如入住海外醫院，請提供國家名稱及英文或中文版本之賠償文件。
7. 如入住醫院管理局醫院，請提供由病房簽發的出院摘要，以便提供病症及手術資料。
8. 若此申請表未完全填妥或未有提供足夠理賠資料，賠償處理將被延誤。

Declaration & Authorization / 聲明及授權書

I/ We acknowledge that I/ we have been provided with a copy of the Personal Information Collection Statement (the "Statement") issued by Assicurazioni Generali S.p.A., Hong Kong Branch ("Generali"). I/ We confirm that I/ we have read and understood the Statement. I/ We agree that Generali may collect, use, store, disclose, transfer and otherwise process my/ our personal data in accordance with the terms of the Statement. I/ We further confirm that I/ we have obtained the express consent of the life insureds and any other relevant individuals (where applicable) for providing their personal data to Generali for the purposes stated in the Statement and for allowing Generali to collect, use, store, disclose, transfer and otherwise process such personal data in accordance with the terms of the Statement.

I / We hereby declare and agree that all statements and information provided herein together with any subsequent alternations or supplementary information are to the best of my / our knowledge and belief complete and true, and all such statement information shall form the basis and become a part of the policy, and understand that if any such statement or information is incomplete or untrue, the coverage provided under the policy may be void. I / We hereby declare that no information which may influence Generali's assessment and acceptance of this application has been withheld and understand that if I / We am / are uncertain as to whether or not a particular information is material, the information should be disclosed. If I / We fail to provide any information requested in this Form, it may result in Generali's inability to process this application.

I / We also hereby authorize any medical attendant, hospital, clinic, insurance company or other organization, institution or person, who / which has any records or knowledge of me / us or my / our health, to divulge to Generali or its authorized representatives or any reinsurers or any tribunal any information he or she or it may have with regards to me / us for the purpose of evaluating this application and any claims arising from the policy. A faxed or photographic copy of this authorization shall be as valid as the original.

如須索取【聲明及授權書】的中文譯本，請電郵至 medicalcs@generali.com.hk 或致電客戶服務熱線(852) 3187-6831 與忠意保險公司賠償部聯絡。

A faxed or photographic copy of this authorization shall be as valid as the original. 此授權書之傳真或影印本同屬有效。

Signature of Member 會員簽署	Signature of Patient (Age 18 or above) 病者 (18 歲或以上) 簽署	Date signed 簽署日期

PART B – To be completed by the Attending Physician, for Hospitalization & Surgical Claim		
Name of Patient :	Date of Admission : (DD/MM/YYYY)	Date of Discharge: (DD/MM/YYYY)
Accommodation Level: □Ward □ Semi Private □ Private □ Hospital Outpatient Division		

1. Clinical History:

1a. Symptom(s)/complaint(s) and underlying cause(s) for this hospitalization/treatment:

1b. Date of the symptom(s) first appeared /accident occurred:

1c. Date on which the patient first consulted you for this medical condition(s)/injury:

1d. When was the patient last seen at your clinic before admission?

2. Hospitalization Summary:

2a. Final diagnosis of the conditions:

2b. Describe the type of treatment / surgical procedure given to the patient:

2c. Please give brief discharge summary (clinical and pathological findings, etiology, complication and follow-up plan)

2d. If the patient has consulted other Physicians during this hospitalization, please provide the following:

Name of Physician consulted ____________________________Reason : ________________________________

What treatment had the physician performed?

2e. Please provide the reason(s) for hospitalization if this type of cases can be managed on day care/outpatient basis:

3. Professional comment: To the best of your knowledge,

3a.) Is condition congenital?
□ No □ Yes, please give details: ________________________

3b.) Has the patient ever had the same or similar conditions or symptoms relating thereto?
□ No □ Yes, please state date of consultation: _______ ________________________________

Diagnosis: ____________________ Treatment type: ____

Others: ____

Is the patient referred by another doctor?
□ No □ Yes, Please state name & address of the referring

If the condition is due to pregnancy, please give approximate date of commencement of pregnancy:
(Mandatory information if it is a maternity claim)

I hereby certify that all information given above is accurate and true to the best of my knowledge.

Physician's Name : ______________________________ Qualification : ___________________________________
(with Chop)

Physician's Signature : ___________________________ Clinic Address and Tel No.: _________________________

Date Signed: ___________________________________ ____

Personal Information Collection Statement

a) From time to time, it is necessary for you to supply Assicurazioni Generali S.p.A., Hong Kong Branch (the "**Company**") with data about yourself(ves), policyholder(s), life insured(s), beneficiary(ies), claimant(s), and/ or other relevant individuals (the "**Personal Data**") in connection with the provision of insurance and/ or related products and services to you, the processing of claims under insurance policies issued and/ or arranged by the **Company**, and/ or the processing of any or all other requests, enquiries and complaints from you.

b) Provision of the **Personal Data** to the **Company** by you is voluntary. However, failure to supply the **Personal Data** may result in the **Company** being unable to provide insurance and/ or related products and services to you, process claims under insurance policies issued and/ or arranged by the **Company**, and/ or process any or all other requests, enquiries, or complaints from you.

c) The purposes for which the **Personal Data** may be used are as follows: (i) processing (including, without limitation, underwriting) and/ or approving applications for insurance and/ or related products and services, and any addition, alteration, variation, cancellation, renewal and/ or reinstatement of such products and services; (ii) administering insurance policies issued and/ or arranged by the **Company**; (iii) processing (including, but not limited to, investigating, analyzing, assessing and adjudicating) and/ or settlement of claims under insurance policies issued and/ or arranged by the **Company**; (iv) exercising rights of subrogation, if applicable; (v) collection of amounts outstanding (if any) from customers; (vi) arranging coinsurance and/ or reinsurance in respect of the insurance policies issued and/ or arranged by the **Company**; (vii) communicating with customers via telephone, mail, e-mail, facsimile and other communication means; (viii) customer services (including, but not limited to, processing enquiries and complaints), marketing, and other related activities; (ix) conducting data matching procedures; (x) designing insurance and/ or related products and services for customers' use; (xi) marketing insurance and/ or other related products and services of the **Company** and/ or its affiliated companies (which includes, but are not limited to, its group companies, parent company, trust companies of the **Company**'s parent company (hereinafter such affiliated companies are collectively referred to as the "**Affiliated Companies**")); (xii) direct marketing of insurance and/ or other related products and services subject to your prior prescribed consent (if any), and you can exercise the right of opt-out by notifying the **Company** at any time; (xiii) statistical or actuarial research of the **Company**, its **Affiliated Companies**, relevant insurance industry associations or federations, supervisory authority, government department and/ or other competent authority; (xiv) complying with the requirements under any laws, rules, regulations, codes, guidelines, court orders, compliance policies and procedures, and any other relevant requirements which the **Company** and/ or its **Affiliated Companies** are expected to comply with, including, without limitation, making disclosures of the relevant information; and (xv) fulfilling any other purposes directly relating to (i) to (xiv) above.

d) The **Personal Data** held by the **Company** shall be kept confidential, but the **Company** may provide the **Personal Data** to the following parties (whether within or outside the Hong Kong Special Administrative Region) for the purposes set out in paragraph (c) above, without prior notification to you and/ or any other relevant individuals to whom the **Personal Data** is related: (i) agents, intermediaries, claims investigation companies, coinsurance companies, reinsurance companies, third party service providers, banks and credit-card companies, health and medical organizations, professional advisers, contractors, business partners, and/ or any other relevant parties, as appropriate, who provide administrative, telecommunication, computer, payment, marketing, investigation, advisory and/ or other services to the **Company** in connection with the operation of its business; (ii)relevant insurance industry associations or federations, and/ or members of such industry associations or federations; (iii) overseas locations or branches, as appropriate, of the **Company** and/ or its **Affiliated Companies**; (iv) persons to whom the **Company** and/ or its **Affiliated Companies** are under an obligation to make disclosure under the requirements of any laws, rules, regulations, codes, guidelines, court orders, compliance policies and procedures, and any other relevant requirements which the **Company** and/ or its **Affiliated Companies** are expected to comply with; (v) any court, supervisory authority, government department or other competent authority (including, without limitation, tax authority) under any laws binding on the **Company** and/ or its **Affiliated Companies**; (vi) lawful successors or assigns of the **Company**; and (vii) persons who owe a duty of confidentiality to the **Company** and/ or its **Affiliated Companies**.

e) The **Company** may verify any or all of the **Personal Data** by using information collected and released or transferred by relevant insurance industry associations or federations, and/ or members of such industry associations or federations.

f) In accordance with the Personal Data (Privacy) Ordinance: (i) any individual has the right to: (A) check whether the **Company** holds data about him/ her and, if so, obtain a copy of such data; (B) require the **Company** to correct any data relating to him/ her that is inaccurate; and (C) ascertain the **Company**'s policies and practices in relation to data and to be informed of the kind of data held by the **Company**; and (ii) the **Company** has the right to charge a reasonable fee for the processing of any data access request.

g) The person to whom requests for access to data and/ or correction of data and/ or for information regarding policies and practices and kinds of data held are to be addressed as follows: Personal Data Protection Officer, Assicurazioni Generali S.p.A., Hong Kong Branch, 21/F, Cityplaza One,1111 King's. Road,Taikoo

Note: In case of discrepancies between the English and Chinese versions of this Personal Information Collection Statement, the English version shall prevail.

收集個人資料聲明

a) 閣下須要不時向忠意保險有限公司香港分行（「本公司」）提供關於閣下自己、保單持有人、受保人、受益人、索償人及／或其他有關人士的資料（「個人資料」），以讓本公 司為閣下提供保險及／或相關產品與服務，處理經由本公司發出及／或安排的保單之下的索償事宜，及／或處理閣下提出的任何或所有其他要求、查詢和投訴。

b) 閣下是自願向本公司提供個人資料的。然而，若閣下未能提供個人資料，可能導致本公司不能夠為閣下提供保險及／或相關產品與服務，處理經由本公司發出及／或安排的保單之下的索償事宜，及／或處理閣下提出的任何或所有其他要求、查詢和投訴。

c) 個人資料可被用於以下用途：(i) 處理（包括但不限於承保）及／或審批保險及／或相關產品與服務的申請，以及該等產品與服務的任何附加、更改、變更、取消、續期及／或 復效；(ii) 管理經由本公司發出及／或安排的保單；(iii) 處理（包括但不限於調查、分析、評估和裁定）及／或理賠經由本公司發出及／或安排的保單之下的索償事宜；(iv) 如適用 的話，行使代位權；(v) 向客戶追收尚欠金額（如有）；(vi) 經由本公司發出及／或安排的保單之下籌劃共同保險及／或再保險；(vii)透過電話、郵件、電郵、傳真及其他通訊方式 與客戶通訊；(viii) 客戶服務（包括但不限於處理查詢和投訴）、推銷，以及其他相關活動；(ix) 進行資料核對程序；(x) 設計保險及／或相關產品與服務供客戶使用；(xi) 推銷本公司及／或本公司的關聯公司（包括但不限於本集團的公司、母公司、本母公司的信託公司（該等關聯公司在下文合稱為「關聯公司」））的保險及／或其他相關產品與服務；(xii) 就閣下事前訂明的同意（如有）約束之下，直接促銷保險及／或其他相關產品與服務，而閣下可在任何時間知會本公司以行使撤回同意的權利；(xiii) 本公司、關聯公司、相關的保險業協會或聯會、監管當局、政府部門及／或其他法定監管機構的統計或精算研究；(xiv) 遵從任何法律、規則、規例、守則、指引、法院命令、合規政策和程序的規 定，以及本公司及／或關聯公司應要遵守的任何其他有關規定，包括但不限於披露有關資料；及 (xv) 實現與上述（i）至（xiv）直接有關的任何其他用途。

d) 由本公司持有的個人資料將受到保密，但本公司可依據以上（c）段所列的用途向以下各方（不論在香港特別行政區境內還是境外）提供個人資料，事前無須知會閣下及／或該等個人資料所涉及的任何其他有關人士：(i) 就本公司的業務營運向本公司提供行政、電訊、電腦、付款、推銷、調查、諮詢及／或其他服務的代理人、中介人、索償調查公司、共同保險公司、再保險公司、第三方服務提供商、銀行及信用卡公司、健康及醫療機構、專業顧問、承包商、業務夥伴及／或任何其他有關各方，以適用者為準；(ii) 相關的保險業協會或聯會，及／或該等協會或聯會的成員；(iii) 本公司及／或關聯公司的海外辦事處或分行，以適用者為準；(iv) 根據任何法律、規則、規例、守則、指引、法院命令、合規政策和程序的規定，以及應要遵守的任何其他有關規定之下，本公司及／或關聯公司負有義務須向其作出披露的人士；(v) 根據對本公司及／或關聯公司有約束力的任何法律之下，本公司及／或關聯公司須向其提供資料的任何法院、監管當局、政府部門或其他法定監管機構（包括但不限於稅務局）；(vi) 本公司的合法繼承人或受讓人；及 (vii) 對本公司及／或關聯公司負有保密責任的人士。

e) 本公司可使用由相關的保險業協會或聯會及／或該等協會或聯會的成員所收集及發放或轉移的資料，來核實任何或所有個人資料。

f) 根據《個人資料（私隱）條例》：(i) 任何人士均有權：(A) 查詢本公司有沒有持有其資料，如有的話，可取得一份該等資料；(B) 要求本公司改正其任何不正確的個人資料；及 (C) 查明關於本公司的個人資料政策和處事常規，並可獲通知有關本公司所持個人資料的種類；及 (ii) 本公司有權就處理任何查閱個人資料的要求之下收取合理的費用。

g) 如欲查閱及／或改正個人資料及／或查詢關於本公司的政策和處事常規及所持個人資料的種類，請向以下人員提出要求：個人資料保護主任，忠意保險有限公司香港分行，香港英皇道1111號太古城中心一期21樓。

附註：本收集個人資料聲明的英文及中文版本之間如有任何歧義，概以英文版本為準。

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
7/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7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 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)
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) 索償申請人姓名(英文) Only applicable for fatal case 只適用於死亡個案	Name of Claimant (Chinese) 索償申請人姓名(中文) Only applicable for fatal case 只適用於死亡個案	Claimant's HKID No/Passport No 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) 父母/合法監護人姓名(英文) Only applicable if the Insured is below the age of 18 只適用於受保人未滿18歲的情況	Name of Parent/Legal Guardian (Chinese) 父母/合法監護人姓名(中文) Only applicable if the Insured is below the age of 18 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 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	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，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
☐ Critical Illness 危疾
☐ Broken Bone 骨折
☐ Hospital Income 住院現金
☐ Permanent Disability 永久傷殘
☐ Other, please specify 其他，請詳述： ______
☐ Hospital Expenses 住院醫療費用
☐ Accidental Death 意外死亡

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 ______

☐ Please "√" this box for return of Certified True Copy ("CTC") of your original medical receipts after claim is finalized. Original medical receipts will not be returned regardless you tick the box or not.
如欲在完成此索償個案後索回醫生的發票和收據正式影印本，請在空格內填上「√」號。不論閣下是否填上此空格，正本文件也將不獲發還。

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. We will facilitate payment by HKD cheque delivered to the Policy Holder's/eligible Claimant's mailing address if we cannot proceed with the selected payment method.
3. 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. 如無法使用以下所選擇的支付方式，美亞保險會以港幣支票作為賠償方式並郵寄往受保人/ 符合條件的索償者的通訊地址。
3. 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 HKD5,000. **只適用於不超過港幣5,000 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）
	或 or
	☐ Hong Kong Dollar Cheque 港幣支票

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 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)		
(FPS) (轉數快) Telephone no. 電話號碼 +852	或 or	(FPS) (轉數快) E-mail address 電郵地址	或 or	FPS ID 快速支付系統識別碼

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

Documents required under Section 3:

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.

第三部份所需文件：

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 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. / 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
Part of body affected 身體受傷部位	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。	
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)	Address 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 **FROM 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 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	
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	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

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

Name of agent/broker 經紀姓名	Code 編號	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	Email address 電郵地址

09/2020