AIA International Limited
(Incorporated in Bermuda
with limited liability)

GROUP MEDICAL INSURANCE HOSPITALIZATION & SURGICAL CLAIM FORM

(This form is applicable to both inpatient and outpatient surgical claim)

PART I Member Information TO BE COMPLETED BY THE MEMBER / INSURED EMPLOYEE

*** Please complete all the information below, otherwise, it cannot be processed. ***
** Please provide contact information. It will be updated to our record in accordance with the arrangement with your employer. **

1. Group Policy No. :*	7. Name of Employer / Group Policyholder :*
2. Name of Insured Employee / Member : *	8. HK/Macau ID No. of the Insured Employee / : *
3. Mobile number of Insured Employee : **	9. Claimant Member ID (10 digits no. shown in the medical card) (**Compulsory**) ( )( ): *
4. E-mail Address of Insured Employee : **	***Please complete items 10 to 11 if item 9 cannot be provided ***
5. Name of Claimant / Patient : *	10. Certificate No. of the Insured Employee : ***
6. Relationship to Insured Employee / Member : * ☐ Self ☐ Spouse ☐ Children ☐ Others : _____	11. Employee No. of the Insured Employee : ***

12. Have you / the claimant had any prior treatment for this or related conditions?

☐ No ☐ Yes _____ Date(s) _____

Address _____

13. Are you / the claimant making any other insurance claim as a result of this hospitalization / surgery?

☐ No ☐ Yes Name of Insurance Company : _____

Policy No. : _____ Type of Compensation : _____

14. Will you / the claimant also apply for insurance claim under any individual policy(ies) with AIA (where applicable) by this claim if the medical expenses exceed the coverage amount of the Group Policy? / ( ) ?

☐ No ☐ Yes If yes, please specify the Policy No. : _____ Agent Code

Declaration and Authorization

I / We hereby irrevocably authorize:

(i) any organization, institution or individual that has any record or knowledge of

(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

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 nece

: ( ) ( )

PART II – TO BE COMPLETED BY THE SURGEON OR ATTENDING PHYSICIAN

Patient Name: /Macau ID Card No.:
: _____ / : _____

1. a. What was the period of hospitalization?
Admission Date Discharged Date

_____
_____

_____
_____

_____
_____

2. a. Please give chief complaint / diagnosis for this hospitalization.

_____

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

_____

_____

8. Was the condition caused by or in any way associated with the conditions mentioned below?

Conditions	Yes	No
a. the influence of drugs or alcohol intake?		
b. AIDS, venereal disease or sexually transmitted disease?		
c. infertility or sterilization?		
d. cosmetic or plastic surgery?		
e. mental or nervous disorder?		
f. congenital deformities or anomalies?		
g. suicide, insanity or self-infliction? ,		
h. correction of eye sight?		

9. a. Were the treatment(s), the medical test(s) and the length of stay in hospital (if any) directly related to the current diagnosis, and were medically necessary and recommended by you? ( )
?

Yes No

: ( ) ( )