AIA International Limited
(Incorporated in Bermuda with limited liability)
Pre-approval Enquiry 預先批核服務查詢

Hong Kong 香港
Hotline 熱線： CEO plan 至尊醫療計劃 (852) 2232 8870
Other medical plan 其他醫療計劃 (852) 2232 8888
Fax 傳真： (852) 3118 9083

Macau 澳門
Hotline 熱線： (853) 8988 1822
Fax 傳真： (853) 2831 5900

Simple guide for Medical Expense Pre-approval Service

(Only applicable to AIA designated medical plan)

醫療費用預先批核服務簡易指南

（只適用於AIA指定之醫療保障計劃）

1

Fill out and return the Pre-approval Form to us
at least 2 - 4 working days prior to admission or day of medical procedure
請填妥預先批核表格，並於入院或接受醫療程序前最少兩至四個工作天交回給我們
E-mail for Hong Kong Customers 電郵地址香港客戶：hk.pre-admission@aia.com
Fax no. for Hong Kong Customers 傳真號碼香港客戶：(852) 3118 9083
Fax no. for Macau Customers 傳真號碼澳門客戶：(853) 2831 5900

2

Once pre-approval request is completed, you will be informed for the result
預先批核一經完成，我們會通知您有關結果

3

Once "Credit Facility Service" has been successfully set-up, we will send a "Letter of Guarantee" (LOG) to the concerned hospital. Upon registration at hospital, please present insured's identification document for verification and notify hospital that "Letter of Guarantee" has been arranged by AIA
「免找數服務」一經安排，我們會向有關醫院發出「付款保證書」。
於醫院登記時，請出示受保人之身份證明文件以作核實，並通知醫院AIA已為病人發出「付款保證書」

4

The hospital will send us the bills and we will settle the approved medical expense on behalf of you. Upon claim assessment is completed, if the medical expense exceeds the payable amount under eligible benefit, a Shortfall Notification will be sent to Policyowner and the designated credit card will be automatically charged with the shortfall amount 14 days from the date of the notification
完成治療後，醫院會直接向我們遞交醫療單據，我們會替您直接繳付有關已獲批核的醫療開支。
當理賠程序完成後，如有關醫療開支高於合資格保障應支付的賠償額，
我們會向您發出「差額付款通知書」，並於發信日十四天後直接從授權的信用卡中扣除。

5

For enquiry, please contact AIA Pre-approval Hotline 如有查詢，歡迎致電友邦預先批核服務熱線:
For Hong Kong Customers 香港客戶：(852) 2232 8870 (CEO plan 至尊醫療計劃) 或
(852) 2232 8888 (Other medical plan 其他醫療計劃)
For Macau Customers 澳門客戶：(853) 8988 1822
For Mainland China Customers 中國內地客戶：400-8428009
(IDD function is required to get through the Toll Free Hotline 客戶電話須有國際長途功能才能打通免費專線)

Note to take:

i) Pre-approval Service or Credit Facility Service is not a contractual service but an administrative arrangement offered in our absolute discretion in respect of covered expenses incurred. It is subject to termination at any time without prior notice.
醫療費用預先批核服務或「免找數服務」為一項就受保人於治療期間所衍生的受保開支而設的行政安排，而並非保單保障內容，我們有權隨時撤銷此項服務而毋須另行通知，並保留絕對決定權。

ii) If treatment or hospitalisation is due to illness/disability classified under exclusion or whatsoever, no LOG will be issued
如因不受保事項而引發之治療或住院，均不會獲發「付款保證書」

iii) You will be required to provide treatment information and authorise AIA to collect any shortfall including any uncovered items, etc. if any, from your authorised credit card account
您須提供治療資料及授權友邦從您授權的信用卡帳戶中收取差額費用包括不受保障項目等（如有）

iv) The actual date of claims notification depends on the submission of required documents by the hospital
賠償通知的實際日期須視乎醫院遞交齊備文件所需日數而有所不同

v) All the claims settlement will be subjected to the final bill and the policy terms & conditions
所有賠償決定受醫療賬單及保單條款及細則約束

OPCLM113.0722

AIA International Limited
(Incorporated in Bermuda with limited liability)
Pre-approval Enquiry 預先批核服務查詢

Hong Kong 香港 Hotline 熱線： CEO plan 至尊醫療計劃 (852) 2232 8870
Other medical plan 其他醫療計劃 (852) 2232 8888
Fax 傳真： (852) 3118 9083

Macau 澳門 Hotline 熱線： (853) 8988 1822
Fax 傳真： (853) 2831 5900

MEDICAL EXPENSE PRE-APPROVAL FORM
醫療費用預先批核表格

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

Please complete this form and return it to us by fax or e-mail at least 2 - 4 working days prior to admission or date of medical procedure.
請填妥此表格並於入院或接受醫療程序前最少兩至四個工作天，以傳真或電郵方式遞交。

Policy Number
保單號碼：(如多於一份醫療保單，請填寫所有保單編號)

Name of Policy Owner
保單持有人姓名：

Name of Insured (Patient)
受保人（病人）姓名：

Insured (Patient) I.D. Card / Passport Number
受保人（病人）身份證/護照號碼：

Contact Telephone No.
聯絡電話號碼：

Contact Telephone No. in U.S.
美國聯絡電話號碼：

E-mail Address / Fax. No.
電郵地址或傳真號碼：

For proper follow up on your medical expense pre-approval progress, your AIA financial planner / broker / IFA of your latest inforce policy can view this medical expense pre-approval information if no specific agent / broker / IFA / TR information is provided at below.
為了妥善地跟進您的預先批核申請進度，若於以下沒有提供指定營業員 / 保險或理財顧問 / 業務代表資料，您最新生效保單的友邦財務策劃顧問 / 保險或理財顧問將能夠查閱是次申請資料。

☐ **If you do not agree on the above arrangement, please mark «✓» in the box.** 如果您不同意上述安排，請於空格內上劃上✓號。

Area Code
區域編號

Agency / Broker Name
營業員組別 / 經紀名稱

Agent / Broker Code
營業員號碼 / 經紀號碼

Agency Code
營業員組別編號

Agent / TR's Name
營業員 / 經紀姓名

Agent / TR's Tel. No.
營業員 / 經紀聯絡電話

TR Membership Number 業務代表會員號碼 ☐ PIBA ☐ CIB ☐ ANG

Are you making any AIA Group Policy or other insurance or compensation claim as a result of this treatment? ☐ Yes 是 ☐ No 否
有關是次治療，閣下有否向友邦團體保單或其他保險公司 / 機構申請賠償?

If "Yes", please provide the following information 如有，請提供下列資料:

Name of AIA Group Policy Employer / Other Insurance Company / Organisation
友邦團體僱主名稱 / 其他保險公司/機構名稱:

Group Policy No. / Certificate No. / Policy No. / Membership No.
團體保單號碼 / 受保證書編號 / 保單 / 會員編號

PLEASE COMPLETE QUESTIONS 1 TO 5 IF HOSPITALISATION IS DUE TO ACCIDENT
因意外受傷入院請填寫問題1至 5

1. Date and time of accident 意外日期及時間： MM月 DD日 YYYY年 ☐ A.M. 上午 ☐ P.M. 下午 HR時 MIN分
2. Where and how did the accident happen 意外地點及經過：
3. Part of body injured and type of injury 受傷部位及傷勢：
4. Present occupation (if more than one, state all) and exact nature of occupational duties 現職（若有兼職請列明）職位及職責：
5. Name and address of business or employer 公司或僱主名稱及地址：

PLEASE COMPLETE QUESTIONS 6 TO 8 IF HOSPITALISATION IS DUE TO ILLNESS 因病入院請填寫問題 6至 8

6. Give a brief description of symptoms 描述病徵及病狀：
7. How long have these symptoms existed prior to the first consultation? 該等病徵在首次求診前已存在多久？
8. Give details of consultations 診治詳情
   a) The doctor first consulted for this illness 首次就診的醫生資料： Date 求診日期 MM月 DD日 YYYY年
      Name and address of doctor / hospital 醫生 / 醫院名稱及地址：
   b) The doctor who referred the insured to hospital / other doctors seen for this or similar past condition 建議入院的醫生資料 / 其他曾診治此病或過往同類病況的醫生資料： Date 求診日期 MM月 DD日 YYYY年
      Name and address of doctor / hospital 醫生 / 醫院名稱及地址：

No Claim Discount (NCD) (Only Applicable to product with NCD) 無索償折扣（只適用於享有無索償折扣的產品）

Important Note 重要通知

If a claim that arose in any previous Policy Year is eventually payable or paid by the company after the policy owner has earned the NCD and thereby paid a discounted premium, the company will use the actual number of Claims Free Years and its corresponding NCD to recalculate the actual eligible discounted premium.

若保單持有人獲得無索償折扣並已支付折扣後的保費，及後本公司若須就以往任何保單年度所出現的索償而作出應付或已付賠償，本公司將會按照實際的無索償年度及其相應的無索償折扣重新計算實際之合資格的折扣後保費。

Declaration and Authorization 聲明及授權

☐ I / We represent that I am / We are the Owner / Assignee / Trustee / Beneficiary (as the case may be) under the policy(ies) as given on this form. Unless putting a tick ✓ in the above box, I / We hereby give my / our irrevocable consent to the company to deduct any balance in excess of the actual eligible discounted premium recalculated in accordance with the eligible NCD and related levy (if any) from any insurance proceeds.
本人 / 我們聲明，本人 / 我們為此索償申請書中列明的保單之持有人 / 受讓人 / 信託人 / 受益人（視情況而定）。除非於上列空格劃上✓號，否則本人 / 我們完全同意，公司會從保險賠償金中扣除超出根據實際合資格無索償折扣所重新計算的保費金額及有關保費徵費（如適用）。

DECLARATION AND AUTHORISATION 聲明及授權

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 application or collected, obtained, compiled or held by the Company 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貴公司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以下網址下載：www.aia.com.hk，及可向貴公司索取。

I/We hereby irrevocably authorise:

a. Any organisation, institution, or individual that has any record or knowledge of my / our / the Insured's employment, sick leave records, accident or loss details (of any sorts), health, medical history or any treatment or advice, that when requested by an authorised representative of the Company may disclose any such information. This authorisation shall be valid as the original.
b. This Company or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests to underwrite and evaluate my / our / 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 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. Neither submission of this Pre-Approval Form nor the issuance of Letter of Guarantee by the Company shall be construed as admission of liability on the part of the Company.
d. In the event that the Company has settled any charges not covered in the policy or exceeds my / our / the Insured's eligible benefit limit, the Company shall have the right to deduct any of such charges from the credit card as specified below. However, if the Company cannot collect such shortfall due to insufficient credit available in the credit card account or for any other reason whatsoever, the Company shall have the right to setoff the shortfall amounts against the amount due or payable to me / us / the Insured from this Policy and/or any policy issued by the Company of which I / we / the Insured am / are / is the owner(s) or trustee(s) including but not limited to any death benefit (to the extent it is permissible by law), dividends or return of premium (for whatever reason).

本人 / 我們茲授權:

a. 任何知悉或擁有本人 / 我們 / 被保人之工作、病假紀錄、意外或損失（任何類別）之詳情、健康狀況、病歷或任何治療或諮詢紀錄及曾 / 為或將為本人 / 我們 / 被保人診治之機構、組織或人士、向貴公司透露有關資料，不得撤回，即使本人 / 我們 / 被保人死亡或喪失能力，此授權書仍然存有法律效力，而本人 / 我們 / 被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. 貴公司或任何其認可之驗身醫生或化驗所，替本人 / 我們 / 被保人進行所需之醫療評估及測試，並對本人 / 我們 / 被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、腎或肝功能失常、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、尼古丁及其代產品之含量等化驗。
c. 遞交此次預先批核表格或由貴公司簽發出住院付款保證信均不能理解為貴公司承擔有關賠償責任。
d. 若貴公司曾為本人 / 我們 / 受保人支付任何不在受保障範圍內的費用，或支付超出有關保障限額的費用時，貴公司將有權從以下指定的信用卡中扣除任何相關的金額。若貴公司因有關信用卡戶口的信用額不足，或不論任何其他原因以至未能收取該筆差額，貴公司將有權把應收款項從此保單，及 / 或任何由貴公司簽發並以本人 / 我們 / 受保人作為保單持有人或信托人的保單所獲支付予本人 / 我們 / 受保人的金額中抵銷扣除，包括但不限於任何身故賠償（法律允許的範圍內）、紅利或保費退還（不論何種原因）。

Signature of Policy Owner / Trustee 保單持有人 / 信託人簽署	Signature of Insured (To be signed by parent / guardian if Insured is below 18 years old) 受保人簽署 (若受保人年齡在18歲以下，本申請表格必須由家長簽署)
Name of Policy Owner 保單持有人姓名	Name of Insured (Patient) 受保人（病人) 姓名
Policy Owner I.D. Card / Passport Number 保單持有人身份證 / 護照號碼	Insured (Patient) I.D. Card / Passport Number 受保人（病人）身份證 / 護照號碼
on 於 ☐☐ MM月 ☐☐ DD日 ☐☐☐☐ YYYY年	on 於 ☐☐ MM月 ☐☐ DD日 ☐☐☐☐ YYYY年

PART II – TO BE COMPLETED BY INSURED/CLAIMANT 第二部份－由受保人或申請人填寫

Credit Card Authorisation Form for Shortfall Collection 收取差額費用之信用卡授權書

If the amount paid by AIA to the hospital exceeds the eligible claims arising from this hospitalisation, this Form authorises AIA to collect the shortfall amount from the following credit card account. The credit card holder must be the Policy Owner or the insured or with direct relationship between the Policy Owner or the insured e.g. spouse or parent or child (documentary proof of relationship might be required). AIA will hold a minimum of HK$5,000 / MOP5,000 (depends on the estimated shortfall amount) from the credit limit of this credit card account until the claim assessment is fully completed. The shortfall notification will be sent to Policy Owner 14 days prior to the collection.

(Please note only Visa or MasterCard issued by bank in Hong Kong / Macau is accepted. For Hong Kong customer, CCB (Asia) UnionPay Dual Currency Credit Card is accepted.)

如友邦直接向醫院支付的費用超出是次住院就合資格保障應支付的賠償額，此授權書將授權友邦從以下信用卡戶口收取有關差額。信用卡持卡人必須為此保單之保單持有人或受保人，或與保單持有人或受保人有直接關係，如配偶或父母或子女（或需提交關係證明文件）。友邦將於信用卡保留港幣5,000元 / 澳門幣5,000元或以上的信用額(視乎預計差額之金額而定)，直至整個理賠程序完結為止。友邦將於收取差額費用十四天前發出差額付款通知書通知保單持有人有關差額詳情。

(請注意，我們只接受由香港/澳門銀行發出之VISA或萬事達卡。香港客戶，我們亦接受中國建設銀行(亞洲)銀聯雙幣信用卡。)

Credit Card Authorisation Form 信用卡付款授權書 (this section must be completed 此部份必須填寫)

Cardholder's Name
持卡人姓名：

Cardholder ID Card / Passport Number
持卡人身份證 / 護照號碼:

XXXX

Relationship with the Insured / Policy Owner:
與受保人 / 保單持有人關係：

☐ Insured / Policy Owner
受保人 / 保單持有人

☐ Insured / Policy Owner's
受保人 / 保單持有人之
(Please specify 請註明)

_____

_____

Credit Card Account No.
信用卡號碼：

				-					-					-				

Credit Card Expiry Date
信用卡到期日：

		-		

I hereby authorise and direct AIA to debit the outstanding shortfall due from my credit card account
本人授權及指示友邦從本人信用卡戶口扣除到期之差額費用

Cardholder's Signature
持卡人簽署：

on 於 | | | | | | | | | | |
MM月 DD日 YYYY年

Contact no. 聯絡號碼：

PART III－TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SURGEON AT THE CLAIMANT OWN EXPENSES
第三部份－申請人自費由主診醫生 / 手術醫生填寫

Name of Patient 病人姓名：

ID Card / Passport Number of patient
病人之身份證 / 護照號碼：

Sex 性別：
☐ Male 男
☐ Female 女

Hospital Name 醫院名稱：

(If confine in hospital in Mainland China, please provide full address. 如入住中國內地醫院，請提供詳細地址)

Expected Date of Admission / Treatment
預計入院 / 治療日期：
MM月 DD日 YYYY年

Ward Type 住房類別：
☐ Outpatient 門診 ☐ Day Care 日間護理病房
☐ Standard 普通病房 ☐ Semi-private 半私家病房
☐ Private 私家病房
☐ Other, please specify 其他，請註明 _____

Expected Length of Confinement (number of days)
預計住院日數：

Medical Condition 醫療詳情

1. Chief complaints of the patient relating to this hospitalization / surgery
此次住院 / 手術的主要原因：

2. Onset date of the symptoms / condition
發病日期：
MM月 DD日 YYYY年

3. To the best of your knowledge, has the patient ever had the same or similar conditions or symptoms relating thereto? 據閣下所知，病人以前有沒有患有同類病況？ ☐ No 沒有 ☐ Yes 有
If Yes, please state dates and details. 如有，請說明何時及當時情況。

Treatment Date 診治日期：
MM月 DD日 YYYY年

Details 詳情：

4. Is illness / injury related to the following condition 此疾病 / 受傷是否由以下情況引起:
a) Congenital anomaly 先天性異常 ☐ Yes 是 ☐ No 否
b) Psychiatric condition 精神病 ☐ Yes 是 ☐ No 否
c) Influence of alcohol, drug or intoxicant 酒精藥物或麻醉劑影響 ☐ Yes 是 ☐ No 否
d) Obesity, weight control 肥胖，體重控制 ☐ Yes 是 ☐ No 否
e) Pregnancy, childbirth, abortion 懷孕，分娩，流產 ☐ Yes 是 ☐ No 否

若是，請詳述。 If yes, please describe the details.

5. a) Medical / Surgical Procedure required 建議之醫療 / 手術程序：

b) Type of Anaesthesia 麻醉類別：
☐ General 全身麻醉 ☐ Local 局部麻醉 ☐ Monitored anaesthesia care 監護麻醉管理
(For surgery under Monitored Anaesthesia Care, please specify the reason for hospital stay.
如手術在監察麻醉下進行，請註明住院原因。)

6. Please list out any laboratory test(s) / imaging test(s) / other diagnostic investigations required for this hospitalisation and reasons for the same. 建議之化驗 / 影像檢查 / 其他診斷性檢查及接受該等檢查的原因。

7. Please list out the medication to be used during this confinement. 請詳列是次住院所用之藥物。

8. Estimated Fee 預計費用：

Daily Ward Round Fee 醫生每天巡房費 $ _____
(If more than one doctor, please provide the breakdown and justification. 如多於一位醫生，請列出明細及原因。)

Surgeon's Fee 外科手術費 $ _____
(If more than one surgical procedure, please provide the breakdown. 如多於一項手術程序，請列出明細。)

Anaesthetist's Fee 麻醉師費 $ _____

Operating Theatre Charges 手術室費 $ _____

Operating Appliances, Equipment, Material, etc. Fee 手術用具、儀器及物料等費用 $ _____

Other Hospital Charges 其他醫院費用 $ _____

Total Estimated Fee 預計總費用 $ _____

9. a) Are the treatment(s), the medical test(s) and the length of stay in hospital (if any) directly related to current diagnosis, and are medically necessary and recommended by you? ☐ Yes 是 ☐ No 否
是次檢查、治療及住院日數（如有）是否和上述診斷有直接關係而且是醫療所需及由醫生建議?
If No, please give details. 若否，請詳述之。

Please answer the following questions if the insured requires hospitalization 若受保人需要住院，請回答以下問題：

b) Are the medical test(s) and equipment available only in hospital? 該檢查所需的設備是否僅在醫院可有? ☐ Yes 是 ☐ No 否
If No, please specify the reason for hospital stay. 若否，請註明住院原因。

c) Are the equipment for the surgical procedure available only in hospital? 該手術所需的設備是否僅在醫院可有? ☐ Yes 是 ☐ No 否
If No, please specify the reason for hospital stay. 若否，請註明住院原因。

d) Can the medical test(s) and the procedure be done on an outpatient basis / at day surgery centre? ☐ Can 可以 ☐ Cannot 不可以
該檢查及手術可否在門診 / 日間手術中心進行?
If Yes, please specify the reason for hospital stay 若可以，請說明病人住院的原因。

If No, please give details. 若不可以，請詳述之。

e) Please indicate the clinical risk(s) and medical reason(s) for hospitalization: 請註明臨床風險及須留院的醫療原因：

☐ Current Health Status (Co-morbidity) 現時健康狀況（合併症）：
Please specify 請明確說明：

☐ Expected higher risk at operation 預期較高手術風險：
Please specify 請明確說明：

☐ Expected higher post-operative risk 預期較高手術後風險：
Please specify 請明確說明：

☐ Others, please specify the reason for admission and hospitalization.
其他，請註明必須入院及留院的原因：

f) Is it a case of emergency? 這是否緊急個案？ ☐ Yes 是 ☐ No 否
If yes, please specify. 如是，請明確說明。

I / We hereby declare that the information given on this form is true 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。

Doctor's name 醫生姓名：		Signature of Doctor and Chop 醫生簽署及印章：	
Contact no. 聯絡號碼：			
Fax no. 傳真號碼：		Date 日期：	MM月 DD日 YYYY年