理赔申请表
Claim form

承保方 Insured by

管理方 Administered by

重要信息 IMPORTANT INFORMATION

提出理赔申请时，请以中文或英文填写本申请表并回答所有问题，将完整填写的本申请表连同发票原件一起寄至：
保柏咨询（北京）有限公司，北京市朝阳区亮马桥路甲40号二十一世纪大厦A座308室，邮编 100125

To make a claim, simply complete the questions on this form in Mandarin or English and return it, along with the original invoices to:
Bupa Consulting (Beijing) Co Ltd, Room 308, Tower A, 21st Century Plaza, 40A Liangmaqiao Road, Chaoyang District, Beijing 100125.

如果您在填写本申请表时有任何疑问，请致电4000687866 或+861058541802。

If you have any questions when completing this form, please call 4000687866/+86 10 5854 1802

填写本申请表时请使用黑色墨水，并确保字迹端正、清晰。同时，请确保理赔申请表的各个部分都已完整填写。
请注意，如果理赔申请表的任何部分未填写完整，可能会延误赔款的支付。

请在接受最初治疗之日起的6个月内将本申请表寄给我们。
请确保您已同时附上发票原件 – 复印件、收据和信用卡交易凭单将不被接受。

Please write clearly using black ink. Please ensure that all sections of the claim form are fully completed.
Note that claims payment may be delayed if all sections of the claim form are not completed in full.

This form should be returned to us within six months of the initial treatment.
Please ensure that you always enclose the original invoices – photocopies, receipts and credit card vouchers cannot be accepted.

请就以下各项分别填写一份新的或单独的理赔申请表：
- 每位患者
- 每次住院治疗/日间住院
- 每项病症
- 每种币种

Please complete a new / separate claim form for:
- each patient
- each in-patient / day-case stay
- each medical condition
- each currency

如果您就同一个病症有多张发票，您无需重新寄送额外的理赔申请表。您只需寄送发票，同时附带一封说明信函，注明病症和付款指示即可。但是，如果病症持续时间超过6个月，我们可能要求您填写新的理赔申请表。**请注意，您提供的原始文件将不予退还；若有需要，请致电客服电话：**4000687866/+86 10 5854 1802。

If you have more invoices relating to the same condition, you do not need to send a further claim form. Just send the invoices with a covering letter stating the condition and payment instructions. If the condition continues for more than six months, we may request a new claim form to be completed. **The original documents will not be returned. If you need them, please contact us on 4000687866/+86 10 5854 1802.**

1 患者的详细资料 Patient’s details 由接受治疗的人员填写 to be completed by the person undergoing treatment

患者保单号:
Patient policy number:

BI - [ ][ ][ ][ ] - [ ][ ][ ][ ] - [ ][ ][ ][ ]

称谓:
Title:

名:
First name:

姓:
Family name:

其他名字:
Other names:

出生日期:
Date of birth: 日 D 日 D 月 M 月 M 年 Y 年 Y

通信地址:
Correspondence address:

大楼名称:
Building:

街道:
Street:

镇/市:
Town / city:

邮政/地区代码:
Post / Zip code:

邮政信箱:
PO Box:

地区:
Region:

国家:
Country:

电子邮件:
Email:

电话:
Telephone:

这是您的永久居住地址吗?
Is this your permanent residency address?
是 Yes 否 No

您希望今后所有的信件都发送到该地址吗?
Do you want all future correspondence sent to this address?
是 Yes 否 No

您在哪个国家接受该治疗?
In which country did the treatment take place?

发票使用何种货币?
What are the currencies of the invoices?

索赔总金额是多少?
What is the total amount of the claim?

2 医疗详情 Medical details

(所有项目均由患者的主治医生填写)(all sections must be completed by the doctor in overall charge of the patient's treatment)

医生的详细资料：
Medical Practitioner's details:

姓名：
Name:

地址：
Address:

执业资格：
Qualifications:

病情诊断：
Diagnosis:

患者首次注意到病症的时间：
Onset date when symptoms first noticed by patient: 日 日 月 月 年 年 (D D M M Y Y)

患者初次就医的时间？
When did the patient first see a doctor? 日 日 月 月 年 年 (D D M M Y Y)

治疗详情：
Details of treatment:

手术详情：
Details of operation:

药物详情：
Details of medication:

住院信息：
Hospital admission information:

入院日期：
Admission date: 日 日 月 月 年 年 (D D M M Y Y)

出院日期：
Discharge date: 日 日 月 月 年 年 (D D M M Y Y)

患者住院的医院名称和地址：
Name and address of admitting hospital:

参考号码：
Reference number:

名称：
Name:

地址：
Address:

电话：
Telephone:

传真：
Fax:

电子邮件：
Email:

牙科治疗：
Dental treatment:

- ○ 检查 Check-up
- ○ 预防 Preventive
- ○ 常规/主要修复 Routine / major restorative
- ○ 畸齿矫正 Orthodontics
- ○ 意外事件/紧急治疗 Accident / emergency treatment

治疗详情：
Details of treatment:

3 住院治疗现金津贴 Hospitalisation cash benefit

如果您在医院住院而无需支付费用，但您的保障计划包括了住院治疗现金津贴保障项目，则需要医院填写该部分。
The hospital should complete this section if you have stayed in hospital overnight without charge, and your plan includes a Cash Benefit.

我证实 / I confirm that 患者姓名：/ Name: ______

在以下期间住院，由：/ was in hospital from: 日 日 月 月 年 年 (D D M M Y Y) 到：/ To: 日 日 月 月 年 年 (D D M M Y Y)

并且医院没有收取住宿费用。
and this hospital did not charge for accommodation.

医院需要在理赔单上此处盖章
The hospital needs to stamp this claim form here

重要信息 IMPORTANT INFORMATION

我们能够以80多种币种（包括人民币）支付理赔款项。少数情况下，我们可能无法按照您所要求的币种支付理赔款项，届时我们将以支付保费时所使用的币种支付理赔款项。
We can settle claims in over 80 currencies, including RMB. In a few cases where we cannot settle in the currency requested, we will reimburse you in the currency of your premium.

您希望我们支付给谁？（请只选一个）
Who would you like us to pay? (please tick one only)

- ○ 医生/医院 Doctor / hospital
- ○ 主被保险人 The principal insured
- ○ 患者 Patient

4 理赔款项的支付 Claim payment (请选填A项或B项中的一项)(please complete either A or Section B)

如果您索赔的治疗发生在中国并且需要人民币付款，我们仅能以银行转账形式支付。
请务必提供正确的银行户名，账号，银行名称及银行分行中文信息。
If your claim is for treatment in China and payment is in RMB we can only pay you via bank transfer.
Please be sure to provide correct account number, account name, bank name and bank branch name for RMB bank transfer

A项 – 以支票方式支付理赔款项
Section A - Payment by cheque

您希望我们用何种币种进行支票支付？（请仅勾选一项）
In which currency would you like us to pay the cheque? (please tick one only)

- ○ 发票标注的币种 Currency of your invoices
- ○ 支付保费的币种 Currency of your premium
- ○ 银行账户的币种 Currency of your bank account

请指明：/ Please specify this: ______

付款支票将通过邮寄的方式寄送至首页填写的通信地址。
Cheques payable will be sent by post to the correspondence address provided on the front page.

B项 – 以银行电子转账方式支付理赔款项
Section B - Payment by Electronic Funds Transfer (EFT) to a bank account

银行名称：/ Bank name: ______

分行名称：/ Branch name: ______

SWIFT / BIC 码 *：/ SWIFT / BIC code *: ______ Sort 码（仅限英国）：/ Sort code (UK only): ___ - ___ - ___

账号/ IBAN *：/ Account number / IBAN *: ______

账户名称/收款方：/ Account name / payee: ______

转账币种：/ Currency for the transfer: ______

银行地址：/ Bank address: ______

邮编：/ Post / Zip code: ______ 国家：/ Country: ______

为了能够确保快速和安全地支付赔偿费用，我们强烈建议您提供银行的IBAN和SWIFT码。
***In order to process your payment as quickly and securely as possible, we strongly recommend that you provide both your IBAN and the SWIFT code of your bank branch. Your bank will be able to provide you with this information if necessary.**

我们建议银行转账款项以您账户的币种进行支付。
我们将承担电子转账的手续费并通知我们的银行照此办理，但是我们无法保证银行手续费均被交由我们支付。如果您当地的银行向您收取了电子转账费用，我们将退还该等费用。
如果我们无法直接付款至指定银行账户，或者您没有提供详细的账户信息，我们将以支票方式进行支付。
我们保留向适当人士支付理赔款项的权利 – 例如已故人员的遗嘱执行人或者保障计划下支付医疗费用的连带被保险人。

We recommend that bank transfers are made in the currency of your bank account.
We will instruct our bank to recharge the administration fee relating to the cost of making the electronic transfer to us, but we cannot guarantee that these charges will always be passed back for us to pay. In the event that your local bank makes a charge for an electronic transfer, we will aim to refund this charge.
If we are unable to pay direct to a bank account, or no account details are provided, we will pay by cheque.
We reserve the right to send any benefit due to an appropriate person – for example, the executors of the will of someone who has died or the dependant insured on your policy who has paid the bill for his / her covered treatment.

5 第三方保险公司 Third party insurers

是否可向第三方获得一部分费用的补偿（比如社会保险或意外事故涉及的人员或组织）：
Are some of the costs recoverable from someone else (for example, state insurer or a person / organisation involved in an accident?):

是 Yes ○ 否 No ○

姓名/名称: Name:
地址: Address:
电子邮件: Email:
电话: Telephone:

6 投保声明 Declaration

重要信息 IMPORTANT INFORMATION

授权获取医疗报告：为处理您的理赔请求，我们可能需要向您就诊的医生索取医疗报告。为此目的，我们需要您签署本部分末尾的投保声明以授权我们获取医疗报告。在下述任何情况下，您的医生有权保留报告中的某些或全部信息而不予提供：(a) 他 / 她认为提供医疗报告可能对您有不利影响，或 (b) 医疗报告将表明他 / 她对您的下一步治疗计划，或 (c) 医疗报告将在未经其他人员授权的情况下披露他们的身份（但健康专业人士就您的治疗以其专业身份提供的信息除外）。您的医生也可能就提供医疗报告的服务收取合理费用。

数据保护：
- 就本理赔申请和保单而收集或持有的有关被保险人的个人信息（包括医疗信息），承保方和管理方可为以下目的持有、使用并披露给与其关联的境内外个人或机构：(i) 处理本理赔申请和其他保险相关事宜；(ii) 提供保险服务和进行保单管理；(iii) 调查或防止欺诈或不当理赔申请；以及 (iv) 与被保险人进行联系（包括以市场营销为目的）；
- 特别是，通过本理赔申请表或其他方式提供的与被保险人所接受的治疗相关的医疗信息可与管理和处理保单、治疗或理赔事宜的指定第三方机构以及您的经纪人或顾问共享；及
- 电话通话可能被录音和监听。有关我们如何处理您的理赔请求的全部文件或确认信息将提供给主被保险人。

投保声明：
- 本人确认，就本人所知的所有情况而言，本人在本理赔申请表上所填写的信息均是准确的、正确的和完整的；
- 为本理赔申请之目的，本人授权并要求医院、专科医生、医生和其他医疗服务提供者向永诚财产保险股份有限公司、Bupa 或他们经授权的代理人提供他们所需要的与本人或其他被保险人接受的治疗或其他服务相关的任何信息；及
- 本人已阅读并了解本理赔申请表所包含的有关数据保护的信息，并明示同意永诚财产保险股份有限公司、保柏保险服务有限公司及保柏咨询（北京）有限公司、上述公司其各自所在企业集团的成员及各自的关联公司、服务提供商、代理商和员工接收、传输和处理本人（及其他被保险人）与本理赔申请相关的个人信息（包括但不限于医疗信息和理赔信息）。

Consent to obtain a medical report: In order to process your claim, we may need to apply for a medical report from any doctor who has attended you. To apply, we need you to give your consent by signing the declaration at the end of this section. Your doctor is entitled to withhold some or all of the information contained in the report if (a) he / she feels that it may be harmful to you or (b) it would indicate his / her intentions in respect of you or (c) would reveal the identity of another person without their consent (other than that provided by a health professional in their professional capacity in relation to your care). Your doctor may also make a reasonable charge for his services.

Data protection:
- Personal information (which includes medical information) regarding the insured persons collected or held in connection with this claim and the insurance policy may be held, used and disclosed by the insurer and the administrators to individuals or organisations associated with them (within or outside China) for the purposes of: (i) processing this claim and other insurance related matters; (ii) providing insurance services and policy administration; (iii) investigating or preventing fraud or improper claims; and (iv) communications (including for marketing purposes) to the insured persons;
- In particular, medical information provided in this claim form or otherwise relating to treatment of insured persons may be shared with appointed third parties involved in the management and handling of any insurance policy, treatment or claim, as well as with your broker or adviser; and
- Telephone calls may be recorded and monitored. All documents and confirmation of how we have dealt with any claim you may make will be sent to the principal insured.

Declarations:
- I confirm that the information I have given on this form is accurate, correct and complete, to the best of my knowledge;
- I authorise and request any hospital, specialist, physician or other health provider to furnish Alltrust Insurance Company Limited, Bupa or their duly authorised agents with such information as they may seek in connection with any treatment or other services provided to me or other insured(s) for the purpose of considering this claim; and
- I have read and understood the information in this form regarding data protection, and give explicit consent for Alltrust Insurance Company Ltd, Bupa Insurance Services Limited and Bupa Consulting (Beijing) Co. Ltd, together with members of their respective corporate groups and their associated companies, service providers, agents and employees, to receive, transfer and process my personal information (and that of other insured(s)) with respect to this claim (including but not limited to medical and claims information)

患者签字（如果患者年龄未满18岁由家长或监护人签字） Patient's signature (Parent or guardian if patient is under 18)	日期 Date

如果您对理赔有任何疑问，请联系我们管理方的客户服务团队：

- 电话： 4000687866/+86 10 5854 1802
- 传真： +86 10 5854 1601

请注意，使用电子邮件是为了向您提供方便和迅速的沟通，但我们无法完全保证电子邮件沟通的安全性。一些公司和国家将监视电子邮件往来。
您在选择以电子邮件方式进行沟通时，应当考虑到这点。

If you have any queries regarding your claim contact the general enquiries team of our administrator on:

- Telephone: 4000687866/+86 10 5854 1802
- Fax: +86 10 5854 1601

Email is used for your convenience and speed, but we cannot always guarantee the security of this method of communication. You need to be aware that some companies and countries do monitor email traffic. You need to take this into account when choosing to use this method of communication.

请参阅您的保险文件了解您保险公司的详细信息。
中国上海市浦东新区浦东大道900号华辰金融大厦9楼全球医疗保险业务部邮编：200135

Please refer to your policy document for details of your insurer.
Worldwide Health Insurance Department, Alltrust Insurance Company Ltd. Shanghai Branch.9/F HuaChen Financial Mansion. No.900 Pudong Avenue, Pudong, Shanghai, China. Postcode: 200135.

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