安盛天平

☎: (8621) 61563500
🖷: (8621) 68824600
💻: www.axatp.com

HEALTH LOSS NOTICE

Please complete this form as truthfully and accurately and return with the supporting documents within 30 days after the occurrence of the claimed condition to:

Non-Motor Claims Manager, 19/F, No. 85 Huaihai Road(E), Shanghai, China
Post Code: 200021

Further information / documents may be requested depending on the nature and extent of the claim. Separate forms must be used for different claimants.

THE INSURED PERSON/CLAIMANT

Policy No.	Name	Sex	Age	Occupation	Identity Card Number

Residential Address	Postal Code	Contact No.	E-mail

If Claimant is an Infant, please specify:
Name of Guardian: Relation to Claimant:

ACCIDENT CLAIM （Please fill in this part for accident.）

Date of Accident	Time a.m./p.m.	Exact Place of Accident

Describe in detail how the accident happened

Part(s) of body affected	Nature of Injury

Police reports, if any	☐Yes(Please refer the cognizance)	☐No

DESEASE CLAIM （Please fill in this part for disease claim.）

Symptoms and Diagnosis:

Since when the symptom complained of has existed:	First Consultation Date:	Name of Clinic/Hospital of First Consultation:

Name of Clinic/Hospital:	Name of Attending Physician:	Diagnosis for Disease:

HOSPITALIZATION CLAIM (Please fill in this part for hospitalization claim.)

Name of Hospital:	Name of Attending Physician:

Date Admitted:	Date Discharged:	Diagnosis:

OTHER APPLICABLE INSURANCE

Has the claim been made against other insurance companies? If so, please state:

Name of Insurer	Policy Number
Claimed Item	Claimed / Settled Amount

BANK DETAILS Claim settlement, if any, will be credited to your account by bank transfer. Please provide the following details:

安盛天平

☎: (8621) 61563500
🖷: (8621) 68824600
💻: www.axatp.com

Account Name:	Bank:	Account Number:

CLAIMED ITEM, AMOUNT & SUPPORTING DOCUMENTS

Part 1: ***Hospitalization Benefit***

Claimed Item	Supporting Documents Required	Claimed Amount
Daily Hospital Room and Board	1. Original Medical Record or Discharge Note issued by in-patient, out-patient or emergency unit; 2. Original Medical Expenses Receipts issued by Hospital; 3. Original Medical Examination Report 4. Original In-hospital Services Bills;	
ICU		
Surgical Fee		
Prescription Drugs		
X-rays, pathology, diagnostic tests and procedures		
Other Hospitalization Expense		
Private Nursing		
Company(parents/chil) accommodations		
Pre&post Hospitalization Treatment		
Psychiatric treatment		
Organ Transplant		

Part 2: ***Artificial Prosthesis***

Artificial Prosthesis	1.Document by the shoulder, arm, hand, leg, foot and eye	

Part 3: ***Outpatient Kidney Dialysis/Cancer treatment***

Part 4: ***Emergency Dental***

Part 5: ***Emergency Evacuation and Repatriation***

Part 6: ***Repatriation of Moral remains***

Part 7: ***Outpatient (optional)***

Part 8:***Dental (optional)***

All Claims	1. Copy of claimant's identity card with signature (if claimant is an infant, copy of the payee's identity card with signature is required); 2. Copy of insurance policy / certificate; 3. Copy of claimant's bank book; 4. Other documents as reasonably required by the Company in relation to this claim.

DECLARATION & AUTHORISATION

The undersigned hereby declare that to the best of my/our knowledge and belief, the above statements are fully and truly made. I/We understand that the furnishing of this form to me/us, or its preparation by any representative of AXA Tianping Property & Casualty insurance Company Limited or the acceptance or retention of the proof thereafter by the Company shall not constitute its waiver of any of the conditions of the policy.

The undersigned hereby authorize any physician, medical practitioner, hospital, clinic, police authority, insurance company or any other organization and institution that has any record or knowledge of my / the Insured's health and medical history or any treatment, advice or accident details and that has been or may hereafter be consulted to disclose to or its authorized representatives such information. This authorization shall bind my / the Insured's successors and assigns and remain valid notwithstanding my / the Insured's death or incapacity in so far as legally possible. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Claimant:	Signature of Guardian (If claimant is under the age of 18):
Date:	Date: