

# ICBC-AXA ASSURANCE CO., LTD.

## 工银安盛人寿保险有限公司

### Medical Reimbursement Claim Form

#### 健康险事后理赔申请表

Please complete clearly in block capitals. 敬请用正楷清晰填写以下内容。

Please remember these important points about filling in your claim form: 填写时注意以下重要事项:

- Assessment of your claims may be delayed if you and your medical or dental practitioner do not fill in all the necessary sections of this form. 敬请注意若主治医师或牙医未提供完整医疗信息, 可能导致理赔延迟。
- Return this form to us within six (6) months of the first treatment date. 请于就诊后6(六)个月内提交此表格。
- Always send us the original invoices with this form. Photocopies and receipts will not be accepted. 请同时附上原始发票, 复印件和收据将不予接受。
- Make sure that you fill in sections A to F and that all doctors who have treated you fill in section G (or section H for dental treatment). 请确保您完整填写保单第一至第六部分, 就诊医生填写第七部分(牙医填写第八部分)。

**If the patient is a dependant under the age of 18, the main member must fill in section A to F for the patient.**  
如申请人为18岁以下连带被保险人, 请主被保险人填写A至F部分

#### A – Patient details 申请人信息

Title 称谓: <input type="checkbox"/> Mr 先生 <input type="checkbox"/> Mrs 太太 <input type="checkbox"/> Miss小姐 <input type="checkbox"/> Ms女士 <input type="checkbox"/> Other 其他:		
Family name 姓:		First name(s) 名:
Date of birth (dd/mm/yy) 出生日期(日/月/年):	Sex 性别: <input type="checkbox"/> Male 男 <input type="checkbox"/> Female 女	
Member number 会员编号:	Plan number 保单编号:	
Correspondence address 通信地址:		Postal code 邮编:
Telephone 电话:	Fax 传真:	E-mail 电子邮件:

**Note:** Your Claim status will be sent to you ONLY via the Email you provide to us. Please make sure the email address is valid and correct. 请正确填写有效的电子邮件, 您的理赔信息将只通过电子邮件的方式告知。

Symptoms/condition needing treatment 症状/就症原因:

#### B – Main member details 主被保险人信息

**If the patient is same as main member, please go to section C.**  
如果申请人与主被保险人为同一人, 请跳转至 C 部分

Family name 姓:		First name(s) 名:	
Member number 会员编号:		Plan number 保单编号:	

#### C – Further information 其他信息

Does the patient have another insurance policy that covers medical costs? 您是否还有其他保单保障该项医疗费用?  Yes 是  No 否  
If yes, please give details on a separate sheet. 若有, 请提供明细。

#### D – Payment details 给付信息

Have you personally had to pay costs for the treatment that you are claiming for? 您是否已就此次理赔支付了费用?  Yes 是  No 否  
If yes, and you are personally seeking reimbursement, please complete details below for bank transfer payments: 若是您个人要求获得补偿, 请填写以下赔款信息:  
Bank transfer, Please fill in this information for bank transfer payments: 银行转账, 请填写以下银行转账信息:

Name of your bank 银行名称:		Account number 银行账号:	
Name of account holder 账户持有人姓名:		Address of your bank 银行地址:	
<b>Note:</b> Please ensure the Name of account holder (including sequence, spacing & capitalization) is exactly identical to your bank's records 请确保您提供的账户持有人姓名与银行记录完全一致。			
Bank sort code 银行代码:		Swift Code/Routing Code 电传编码/汇款路径编码:	
Currency of bank account 银行账户币种:			

**Please note** 请注意:

We will not be responsible for any payment shortfall due to exchange rate fluctuations. 我们不承担任何因汇率波动产生的支付不足。

## E – Claim details 理赔信息

Date of treatment 就诊日期	Invoice date 发票日期	Provider name 医院名称	Amount (including currency) 金额(币种)

## F – Signed declaration 签署声明

I declare that all the details provided on this claim form represent a true and accurate statement and that I have not omitted any details pertinent to the circumstances of this claim. I understand that in the event that this claim is found to be fraudulent in whole or in part, I am committing a criminal offence and that this will invalidate the plan and render me liable to prosecution under P.R.C Law. In respect of any medical claim I hereby authorise any Medical Practitioner, Specialist, Consultant, Therapist or other relevant establishment who has previously attended me/or is currently attending me/patient, to provide any details that may be requested by ICBC-AXA ASSURANCE CO., LTD.(ICBC-AXA Life).

I confirm and agree that any personal information collected or held by ICBC-AXA Life, whether contained on this form or otherwise obtained may be used by ICBC-AXA Life, or disclosed to or transferred to any organisation for the purpose of i) assessing this claim and providing on-going insurance cover, customer service and the processing of subsequent claims, ii) processing and effecting payments, iii) providing marketing communications in respect of ICBC-AXA Life, its related products and services and those of its associated companies.

本人在此声明此理赔申请表提供的信息均真实、准确，且未遗漏与此次理赔相关的信息。本人理解若此次理赔被发现全部或部分欺诈，本人将承担刑事责任并将导致本保单无效，根据中华人民共和国法律，本人也将被起诉。对于任何医疗理赔，本人在此授权任何曾经或正在治疗我/病人的执业医师、专家、顾问、临床医学家或其他相关组织根据工银安盛人寿保险有限公司的要求提供任何信息。

本人确认并同意工银安盛人寿保险有限公司由此投保单或以其他方式搜集并持有的任何个人信息可以由工银安盛人寿保险有限公司使用，或为下列目的向任何机构透露或传达：

i) 评估本项投保申请及提供持续的保障、客户服务和理赔程序，ii) 处理并接收保费给付，iii) 提供关于工银安盛人寿保险有限公司、其关联公司的相关产品和服务的市场推广信息。

Patient's/member's signature 病人/成员签字: \_\_\_\_\_ Date (dd/mm/yy) 日期(日/月/年): \_\_\_\_\_

## G – Medical information(except dental) 医疗信息(牙科除外) *This section must be filled by the Medical practitioner/Specialist/Consultant/Therapist. 本部分必须由执业医师/专家/顾问/临床医学家填写*

Note to the Medical Practitioner/Specialist/Consultant/Therapist: Please give this form back to the patient after you have filled it in. For dental treatment, please use section H. (over the page) 请注意：执业医师/专家/顾问/临床医学家填写完毕后，请将此表格归还给病人。如为牙科治疗，请填写第八部分。(下一页)

### 1. Contact details 详细联系资料

Name of medical practitioner/specialist/consultant/therapist 执业医师/专家/顾问/临床医学家姓名:	
Qualifications 从业资格:	
Telephone Number 电话:	Fax Number 传真:

### 2. Referrals 推荐

a) Was the patient referred to you? 该病人是否经人推荐?  Yes 是  No 否

Name of referring practitioner 推荐医师姓名:	Qualifications 职称:
Address 地址:	
Telephone Number 电话:	Fax Number 传真:

b) Have you referred the patient? 您是否推荐该病人?  Yes 是  No 否

Name of specialist/consultant to whom you referred the patient 被推荐专家/顾问姓名:	
Qualifications 职称:	Date of referral (dd/mm/yy) 推荐日期(日/月/年):

### 3. Symptoms 症状

a) Has the patient suffered from the same or similar symptoms before? 该病人以前是否遭受过相同或类似症状?  Yes 是  No 否  
If yes, please give details: 若是, 请提供详情:

b) On what date did the patient first noticed these symptoms (dd/mm/yy)? 该病人最早发现该医疗状况的症状和体征是哪一天(日/月/年)?

c) On what date did the patient first present symptoms to you (dd/mm/yy)? 该病人首次向您陈述该病症是哪一天(日/月/年)?

d) Please give full details of the symptoms needing treatment: 请提供需要治疗的该病症的详细信息:

### 4. Investigation requested 治疗需要

Please give details 请提供详情:

### 5. Diagnosis 诊断

Diagnosis of medical condition, if known 目前所知的对该医疗状况的诊断:

ICD10 code ICD10 代码:

Treatment proposed 治疗建议:

Is a follow-up visit needed? 是否有复诊要求?  Yes 是  No 否 If yes, when(dd/mm/yy)? 若是, 请确认何时(日/月/年)?

### 6. Type of condition 医疗状况类型

In your opinion, is this condition: 在您看来, 该医疗状况是:  Acute 急性的  Chronic 慢性的  Acute episode of a chronic condition 慢性疾病急性发作

### 7. Type of complementary treatment recommended (if relevant) 推荐的治疗种类(若相关)

<input type="checkbox"/> a) Physiotherapy 物理治疗	Number of sessions needed 需要疗程数:
<input type="checkbox"/> b) Osteopathic treatment 整骨疗法	Number of sessions needed 需要疗程数:
<input type="checkbox"/> c) Chiropractic treatment 脊椎指压疗法	Number of sessions needed 需要疗程数:
<input type="checkbox"/> d) Homeopathic treatment 顺势疗法	Number of sessions needed 需要疗程数:
<input type="checkbox"/> e) Acupuncture 针灸治疗	Number of sessions needed 需要疗程数:
<input type="checkbox"/> f) Chinese medicine 中药治疗	Number of sessions needed 需要疗程数:

### 8. Hospital admission 住院治疗

Has the patient been admitted to hospital for this condition? 病人是否因该医疗状况接受过住院治疗?  Yes 是  No 否

If yes, please give admission date (dd/mm/yy) 若是, 请提供入院日期(日/月/年):

And discharge date (dd/mm/yy) 出院日期(日/月/年):

### 9. Cosmetic treatment 整容治疗

In your opinion, is the treatment for cosmetic reasons? 在您看来, 该治疗是否为了整容?  Yes 是  No 否

### 10. Declaration 声明

I declare that to the best of my knowledge and belief the statements made on this claim form are full, true and complete.  
本人声明以本人所知所信在此理赔申请表上的陈述内容是完整、真实和无保留的。

Medical Practitioner's/Specialist's/Consultant's/Therapist's signature 执业医师/专家/顾问/临床医学家签字: \_\_\_\_\_

Date (dd/mm/yy) 日期(日/月/年): \_\_\_\_\_

## H – Dental treatment 齿科治疗 *This section must be filled in by the dental practitioner.* 本部分必须由牙科医生填写

### 1. Contact details 详细联系资料

Name of dental practitioner 牙科医生姓名:

Qualifications 从业资格:

Telephone Number 电话:

Fax Number 传真:

## 2. Symptoms 症状

- a) Was the patient suffering from dental pain when they first visited you? 患者第一次到您处就诊时是否有牙痛?  Yes 是  No 否
- b) Has the patient suffered from the same or similar symptoms before? 患者此前是否出现过相同或相似的症状?  Yes 是  No 否
- if yes, please give dates: 如果是, 请填写出现这些症状的日期:

c) On what date did the patient first notice these symptoms (dd/mm/yy)? 该病人最早发现该医疗状况的症状和体征是哪一天(日/月/年)?

d) On what date did the patient first present these symptoms to you (dd/mm/yy)? 该病人首次向您陈述该病症是哪一天(日/月/年)?

e) Please give full details of the symptoms needing treatment: 请提供需要治疗的该病症的详细信息:

## 3. Treatment 治疗

- a) In your opinion, was the dental treatment: 您认为, 患者需要的牙科治疗属于:  Routine 常规治疗  Emergency 急诊
- b) Please fill in the dental chart by using the abbreviations below: 请使用以下缩写填写牙科图表:

Dental chart 牙科图表																		
	Right 右								Left 左									
Treatment 治疗																		Treatment 治疗
Finding 发现																		Finding 发现
Upper jaw 上颌	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	Upper jaw 上颌	
Lower jaw 下颌	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	Lower jaw 下颌	
Finding 发现																	Finding 发现	
Treatment 治疗																	Treatment 治疗	

Finding 发现:

b = bridge 牙桥  
 c = crown 牙冠修复  
 ca/da/dn = caries/decay/dental necrosis 龋齿/蛀牙/牙齿坏  
 cl = calculus 牙石  
 g = gap closure 间隙封闭  
 gb = gingival bleeding 牙龈出血  
 gi = gingivitis 牙龈炎

gs = gingival swelling 牙龈肿胀  
 i = implant 植牙  
 in = inlay 嵌体  
 m = missing tooth 牙齿缺失  
 p = periodontitis 牙周炎  
 pu/od = pulpitis or odontitis 髓炎 齿髓炎

Treatment 治疗:

AF = amalgam 汞合金填充  
 CF = composite 复合材料填充  
 D = denture 假牙  
 E = extraction 拔牙  
 I = implant 植牙  
 IN = inlay 嵌体  
 M = metal ceramic crown 金属烤瓷牙冠  
 NB = new bridge 新牙桥  
 NC = new crown 新牙冠

O = orthodontics 齿列校正  
 ON = onlay 高嵌体  
 OR = oral radiograph 口腔X光片  
 PR = panoramic radiograph 全景X光片  
 RB = replacement bridge 牙桥更换  
 RC = replacement crown 牙冠置换  
 RCT = root canal treatment 根管治疗  
 S&P = scale and polish 去垢和抛光

If the treatment was NC or RC, was a precious or semi-precious metal used?  Yes 是  No 否  
 如果患者接受了NC或RC治疗, 是否使用了贵金属或半贵金属?

If yes, what?  
 如果是, 使用了哪一种贵金属或半贵金属?

If the treatment was IN or ON, was a precious or semi-precious metal used?  Yes 是  No 否  
 如果患者接受了IN或ON治疗, 是否使用了贵金属或半贵金属?

If yes, what?  
 如果是, 使用了哪一种贵金属或半贵金属?

## 4. Declaration 声明

I declare that to the best of my knowledge and belief the statements made on this claim form are full, true and complete.  
 我声明, 我已尽我所知全面地, 真实地并完整地填写了本表格的内容。

Dental practitioner's signature 牙科医生签名: \_\_\_\_\_ Date (dd/mm/yy) 日期(日/月/年): \_\_\_\_\_

## No claims discount 无索赔折扣

Applies to individual and family plans only and not Group Plans 仅适用于个人计划, 团体计划不适用

Please note: By making this claim, you will affect your no claims discount. 请注意: 一旦提出理赔, 将影响您的无索赔折扣。

## Excess 免赔额

If you have an excess on your plan, this will be deducted from any reimbursement. 如果您的保单有免赔额, 任何补偿中都将扣除这一数额。

## Checklist 清单

Have you enclosed: 您已附上:

- A fully completed claim form with signed and dated declaration 完整填写并签署姓名日期的理赔申请表
- Original itemized invoices (copies will not be accepted) 详细列明的原始发票(不接受复印件)
- Original admission and discharge form if claiming Hospital Cash Benefit 如果申请住院现金, 原始的入院和出院单据

Please send your claim to below address 请将您的理赔寄送到如下地址:  
 Health Care Claim team, No 8, An Lan Road, Shanghai 200011, China  
 上海市安澜路8号全球医疗理赔部