

## Worldwide Group Health Plan Claim Form

### 环球团体医疗保险索赔单

**Please mail the claim form and ORIGINAL invoices to the address below:**

**请将此理赔表格连同原始账单邮寄到:**

Euro-Alarm (Beijing) Co., Ltd., 302, Bld. C, East Lake Villas,  
 35 Dongzhimenwai Dajie, Dongcheng District, 100027 Beijing, China.

欧乐旅行援助, 中国北京市东城区东直门外大街 35 号  
 东湖别墅 C 座 302, 邮编: 100027

<b>Insured's Personal information</b> 被保险人个人信息	Company 单位		Policy No. 保单号	
	Membership Number (on membership card) 医疗卡卡号 (保险卡上)		Insurance Program 保险计划	
	Name 姓名		Passport / ID No. 护照/身份证号	
	Private address 家庭住址		Tel. 电话	
	Postal code 邮编	E-mail 电子邮件	Fax 传真	
<b>Applicant's information</b> 申请人个人信息 (When different from above) (与上不同时)	Name 姓名		Passport / ID No. 护照/身份证号	
	Relation to Insured 与被保险人的关系		Tel. 电话	
<b>Compensation claimed</b> (please attach original documents)  赔偿申请 (请附上原始文件)	<b>Expenses incurred on the account of the illness/injury?</b> 与伤/病相关的费用		<b>Currency</b> 币种	<b>Amount</b> 金额

<b>Other insurance</b> 其他保险	Company 保险公司	Policy No 保单号
	Has the claim been reported to this company? Yes <input type="checkbox"/> No <input type="checkbox"/> 是否在此公司申请过理赔? 有 无	
<b>Payment Bank Account</b> 付款银行账户	<b>Note: If you'd like to have foreign currencies transferred to your Chinese account, you yourself have to bear the transaction costs occurred. However, it is FREE for you to have RMB transferred to a Chinese account, or any other foreign currencies to an overseas account.</b> <b>注意: 如果您希望我们向您的中国账户支付外汇, 您需要自行承担相应的手续费。但是, 我们可以免费向您的中国账户支付人民币, 或者海外账户支付其他货币种类。</b>	
	Bank name 银行名称	Account holder 户名
	Bank Address 银行地址	
	Bank account No. 账号	Branch code (BLZ, ABA sort code) 分支编码 (BLZ, ABA 等类似编码)
	BIC/SWIFT-Code:	IBAN:
<b>Signature</b> 签名	<p>I hereby accept that the Insurance Company or the Assistance Provider appointed by the insurance company procures information about the state of my health with a view to obtaining the information necessary for the evaluation of the insurance event and for the assessment of the claim. My acceptance comprises medical reports from the date of which the policy came into force and until the final assessment date of the benefit, and any other supplementary medical records that may be deemed necessary by the Insurance Company or the Assistance Provider for the purpose of evaluating issuance event or assessing claims.</p> <p>The reports can be procured from the health care sector, hospitals and healthcare institutions, public authorities, insurance companies and pension funds.</p> <p>Other insurance companies, pension funds and other authorized persons within the health care sector, involved in the case, are allowed to become acquainted with the medical records procured.</p> <p>I hereby authorize the Insurance Company via its appointed Assistance Provider Euro-Alarm (Beijing) Co., Ltd. to act on my behalf and settle payments directly with hospitals, clinics and other service providers. By this authorization I furthermore accept that the insurance payments for said services will be paid directly from the Insurance Company via the Assistance Company to the service providers.</p> <p>I declare that the above information is truthful and complete and has been entered in good faith.</p> <p>本人在此同意, “保险公司”或其指定的“救援服务公司”为评估本人保险事宜及核定保险索赔之目的, 有权获得有关本人健康状况的信息, 包括自保单生效之日起至保险权益的最终核定之日止的医疗记录, 及“保险公司”或其指定的“救援服务公司”在评估、核定过程中认为必要的其他补充性医疗记录。</p> <p>记录可从医疗部门、医院、医疗机构、公众权威机构、保险公司和养老基金那里获得。</p> <p>其他保险公司、养老基金、医疗部门及其他经授权人士, 凡与本人保险事宜有关的, 亦有权了解所取得的医疗记录。</p> <p>本人在此授权“保险公司”经其指定的“救援服务公司”即“欧乐旅行援助(北京)有限公司 Euro-Alarm (Beijing) Co. Ltd.”代表本人直接与医院、诊所、和其他服务机构进行交涉并直接付款。在此授权中, 本人进一步同意, 有关该等服务的保险付费, 将由“保险公司”经“救援服务公司”直接支付给服务机构。</p> <p>本人声明, 上述信息真实、完整, 且以诚信原则提供。</p>	
	Applicant's signature 申请人签名	Date 日期
	_____	_____

**Please note: If there are special circumstances that are not covered by sections of this form, please give us the details on a separate sheet together with this form. 请注意如果此表中所列各项未能涵盖一些特殊情况, 请随此表附上单独写有详情的文件。**

To be completed by the treating doctor in English or Chinese or alternatively please attach the original diagnosis and prescription

以下由主治医生用正楷中文或英文填写或者附原始病历及药方

<b>Medical provider information</b> 医疗提供方信息	Name of Doctor 医师姓名	Qualifications 职称	
	Name of hospital 医院名称	Passport No. 护照号码	
	Address 地址	Tel. 电话	
	Postal code 邮编	E-mail address 邮箱	Fax 传真
<b>Medical Information</b> 医疗信息	Has treatment guaranty been obtained? 是否收到付款保证?	Yes 是	No 否
	Indicate type of treatment received? 清指出接受治疗的类型	Optional 选择性	Emergency 急诊
	If emergency, please specify date of emergency. (dd/mm/yyyy) 如果是急诊, 请指出急诊发生日期。(日/月/年)		
	Has treatment been received for similar illness before? 以前是否因为相似疾病接受过治疗?	Yes 是	No 否
If yes, please indicate first date. (dd/mm/yyyy) 如果是, 请指出首先接受治疗的日期。(日/月/年)			
<b>Details of treatment</b> 治疗详情	Please provide full details of the medical condition requiring treatment, including the ICD-Code 9 or 10 (International Classification of Disease) 请提供需要接受治疗的病情, 包括 ICD 编码 9 或者 10。		
<b>Doctor's signature</b> 医师签名	Date (dd/mm/yyyy) 日期(日/月/年)		