China Continent Property & Casualty Insurance Company
GBG / TIECARE INTERNATONAL

Claim Form – Part A Patient Information
理赔表 – A 部分 病人信息

For a claim to be valid the following two pages (Part A and B) must be completed and submitted to the Shanghai Claims Center within one-hundred eighty days (180) after the first day of treatment.

为确保有效理赔，您必须完整填写以下内容（A 与 B 两部分），并在从治疗之日起的 180 天之内向上海理赔服务中心提出理赔要求。

Pre-authorization is required for certain conditions. Failure to obtain pre-authorization will result in an additional 40% co-payment.

某些治疗须事先授权. 未行使事先授权将导致 40%的额外自负额

1. **Who is this Claim for?** **理赔人** ☐ **Primary Insured 第一被保险人** ☐ **Dependent 被保险人亲属**

NOTE: If claim is for the Primary Insured, please do not fill out Dependent Information
注：如果理赔人是第一保险人，无需填写被保险人亲属信息。

Primary Insured Information 第一被保险人信息	Dependent Information 被保险人亲属信息
English Name 英文姓名: ☐ Male 男	Name 姓名: ☐Male 男 ☐Female 女
Chinese Name 中文姓名: ☐ Female 女	☐Spouse 配偶 ☐Child 子女
Employee Number(工号):	DOB 生日: MM 月/ DD 日/ YY 年
☐Married 已婚 ☐Single 未婚	Address 地址:
DOB 生日: MM 月/ DD 日/ YY 年	
Address 地址:	
Telephone 电话: Fax 传真:	Telephone 电话: Fax 传真:
Email 电子邮件地址:	Email 电子邮件地址:
Policy # (from your membership card): 保险号码（来自您的成员卡）	Relationship to insured 与被保险人关系:
Name of employer (Group policy only): 所在公司名称（仅限于团体保险政策）	Date dependent insurance began 亲属保险开始日期: MM 月/ DD 日/ YY 年

2. **Describe Injury or Illness 受伤或疾病描述**

Describe the treatment given 接受的治疗:
Date occurred 发生时间： MM 月/ DD 日/ YY 年
Where Injury / Illness occurred 受伤/疾病发生地点:
Is this the first time you sought treatment for this Injury/Illness? 受伤/疾病是第一次就诊吗？ ☐ Yes 是 ☐ No 否
If No, give the date you first consulted a physician for the same Illness/Injury: 如不是，请写出第一次就诊日期:
Full name, contact no. and address of the physician: 医生的名字，联系电话和地址:

Are you also covered by another insurance policy? 您购买了其他的保险吗？☐ Yes 是 ☐ No 否
Policy # 保险号码:
Name of other insurance company 其他保险公司的名称:

3. **Payment Information 给付信息**

1) RMB Bank Account Information (Bank account must be located in Mainland China):
Account #: Name on Account:
Name of the Bank and Branch:
2) Electronic Transfer Information (US Bank within US only) 电子转账信息(仅限美国境内银行)
Account #: Name on Account:
Routing (ABA) #: Bank Address:
Name of the Bank:

The above answers are true and correct to the best of my knowledge and belief. I authorize any physician, medical institution, druggist, insurance company, employer, labor union, or association to release information to Global Benefits Group as is required to properly pay all benefits, if any, due me, or my dependent for this claim. A photocopy of this authorization shall be considered as effective and valid as the original.

我尽我所知回答以上问题，相信所填内容正确属实。如果此理赔需要，为使我、我的家属完全得到应偿付的所有保险利益，我授权任何医生、医疗机构、药剂师、保险公司、雇主、工会或协会将以上信息告知 Global Benefits Group。此授权的复印件与原件应被视为具有同等效力。

（Primary Insured's Signature 第一被保险人签字） **（Dependent's Signature 亲属签字）** **(Date 日期) MM 月/ DD 日/**

Claim Form – Part B Medical Information

理赔表 – B 部分 医疗信息

4. Medical Information - To be Completed by the Treating Physician 医疗信息 – 由治疗医师填写

Doctor's name 医师姓名: Phone # 电话:

Hospital's name 医院名称: ____________________ Address 地址: ____________________

Please give your diagnosis of the Illness/Injury (if maternity, state delivery date) 请就受伤/疾病给出诊断（如果是生育，请说明分娩日期）____________________

When did patient consult you for this condition? 病人何时到您处就诊? Date 日期: MM 月/ DD 日/ YY 年

When did patient seek treatment for this condition for the first time? 病人此种疾病第一次就诊时间? Date 日期: MM 月/ DD 日/ YY 年

Treatment is related to (Please circle if related to one of the following items) 本次治疗是否与以下相关（如是，请标出）:

1) Maternity 产前检查或生育 2) Physical therapy 物理治疗 3) Full body check up 全身体检

4) Immunization or wellness check up 注射疫苗或单项体检 5) Dental 牙科 6) Vision 视力

Patient's chief complaint 病人的主诉: ____________________

Physical examination 体格检查: ____________________

Necessary lab tests 病人需要做的实验室检查有: ____________________

Lab tests' results 实验室检查结果: ____________________

Please state name of drug(s) and dosage(s) below 药品的名称和剂量: ____________________

Will illness/injury require follow up treatment? If so, please give details. 受伤/疾病需要后续治疗吗？如果需要，请说明详情:

Date of service 服务日期	Description of medical procedures 医疗程序描述	Charges 收费
	Consultation fee(s) 诊疗费	
	Drug fee(s) 药费	
	Lab test fee(s) 实验室检查费	
	Treatment fee(s) 治疗费	
	Others 其他	

MM 月/ DD 日/ YY 年

Date 日期 **Signature of treating physician 治疗医生签名** **Print name and title 印刷体姓名和职位**

Shanghai Claims Center · Room 303, Building No. 2, Xindu Garden, Lane 31, Lan Cun Road, Pudong, Shanghai 200127, P.R.C.中国上海浦东蓝村路 31 弄新都花园 2 号 303 室 邮编 200127
Tel: (86-21) 5089-0330 · Fax: (86-21) 5839-0612 · Email: claims@gbg.com.cn