中国太平 CHINA TAIPING

太平财产保险有限公司
TAIPING GENERAL INSURANCE CO., LTD.

GLOBAL BENEFITS GROUP
Insurance Without Borders

CLAIM FORM 理赔申请表

This claim form is to be used only if your provider did not file claims directly to ICS on your behalf. Return this form ***along with fully itemized bills and diagnosis*** to the address below. International Claims Services must receive claims within one hundred eighty days (180) after first day of treatment.

仅当您的医疗服务机构未直接以您的名义向 ICS（国际理赔服务中心）申请赔理时，您才需要填写此表。将本申请表填妥后，***连同完整的收费清单及诊断证明***寄往如下地址。ICS 必须在开始治疗之日起的（180）天内收到理赔申请。

GBG China Claim contact information GBG 中国理赔联系信息:

Shanghai Claims Center ·Suite 3401, Sino Life Tower, 707 Zhangyang Road, Shanghai, 200120 P. R. China 中国上海张杨路 707 号生命人寿大厦 3401 室 邮编 200120; Tel: (86-21)3126 9300; Fax: (86-21)5835-3368; Email: chinaclaims@gbg.com; Claim Status Inquiry: chinaclaims@gbg.com

Policy holder (Primary Insured) Information
持保人 (主投保人) 资料

Name 持保人姓名:	**Employer 雇主名称:**	
Policy No. 保单号码:	**Member No.会员号:**	
Current Resident Address and Country 当前居留国家及居住地址:		
E-Mail 电邮:	**Telephone 电话:**	**Fax 传真:**

Section A
第一部分

Please check who this claim is for 请勾选保险理赔申请人:

☐ **Primary Insured 主投保人**

Name 姓名:	Date of Birth 出生日期:

☐ Male 男 ☐ Female 女

☐ Married 已婚 ☐ Single 单身

☐ **Dependent Insured 附属投保人**

Name 姓名:	Date of Birth 出生日期:

☐ Male 男 ☐ Female 女

Relationship with Primary Insured 与主被保险人关系:

☐ Spouse 配偶 ☐ Child 子女

Current Country of Residence 当前居住国家:

If dependent is a child 21 years and older, is child a full-time student? 如果附属投保人年龄大于 21 岁，那么他/她是否是全职在校生？ ☐ Yes 是 ☐ No 否

If yes, please provide name of school 若是，请填写学校名称:

Location 地址:

All full time students must have a letter verifying full-time student status from their school's registrar office at the beginning of each school year. 所有全职在校生在每学期开学时，必须具有从学校的注册管理处开据的全职学生身份的证明书。

Is this patient also covered by: 申请人是否同时持有及合乎以下保险:

☐ Any other group health plan 其它集体健康保险 ☐ Medicare or other Govt. Agency 联邦医疗健保或其他政府机构的保险

☐ No-Fault auto carrier 无究肇事责任的汽车保险

If yes, provide name and address of other source: 如果选择以上任何选项，请提供其名称及地址:

PAYMENT INFORMATION 付款资讯

Please make payment to 保险理赔受益人:

☐ Member 持保人 ☐ Provider 医疗服务机构

Payment Type (please make payment as marked below): 付款方式(请按照以下方式付款) :

Send check and EOB to 将支票和理赔通知单（EOB）寄至:

☐ Member Address on Part 1 寄至列于持保人资料第一部分的通讯地址

☐ Other Mailing Address 寄至其它通讯地址:

☐ Deposit to CRC*- Claims Reimbursement Card 存入 CRC*- 保险理赔提款卡

* For more Information on the CRC MasterCard Debit card and instructions for Registration: Visit www.gbg.com

* 请登陆 www.gbg.com 网站，查看更多有关于保险理赔提款卡 (借方万事达卡)的详情及注册信息。

☐ Send by Wire Transfer 电汇付款：

Name of Bank:银行名称_____

Name on Account:账户持有人姓名: _____

Account #/IBAN 账号:_____

Routing Number (ABA) for electronic transfer, and/or SWIFT code for Wire Transfers 银行转帐代码 (Routing/ABA Number) 或银行汇款代码 (SWIFT Code):_____

Address of bank for Wire Transfers 电汇收款银行地址:_____

Section B
第二部分

Describe Illness or Injury, how did it occur? 简述疾病或伤情，它是如何发生的?

Date Illness / Injury occurred 患病/受伤日期:

Diagnosis or description of illness or Injury 疾病或伤情的医生诊断或说明:

Is this claim for Maternity treatment? 此次申请理赔是否属于妇产科治疗? ☐Yes 是 ☐No 否

Delivery Date 预产期/分娩日期:

Has diagnosis and/or treatment for same condition or related condition been given previously? If so, state dates, results, kind of treatment, prescribed drugs and name of doctor or facility: 以前是否有过相同或相关的诊断或治疗？如果有，请注明日期、结果、治疗措施、处方药物、以及医生姓名或医疗机构名称:

Was illness or injury due in any way to 请填写疾病或受伤原因:

☐ The patients occupation 职业伤害 ☐ An automobile Accident 汽车意外伤害 ☐Any type of accident 任何其他意外伤害

If yes, provide details, including date of accident: 如果选择以上任何选项，请提供细节，包括发生日期:

Doctor/Facility Information:医生/医疗机构资讯:

Doctors Name:医生姓名:	Phone # 联系电话:
Address / Country 通讯地址及国家:	Facility name:医疗机构名称:

The following treatments and or prescribed drugs were provided to me and the charges for each are listed below. (ATTACH RECEIPTS in order to receive payment) 以下分列出所有接受的医疗服务和(或)处方药物及其费用 (依照保险理赔条款,需附上所有费用收据及帐单)。

Date of Service治疗服务日期			
MM/DD/ YY月/日/年	Description of each service and/or prescribed drug描述每项医疗服务和或处方药物	Cost费用	Currency货币
	Total Amount Paid by Patient 患者支出金额合计		
	Total balance still due to provider未付医疗机构的差额合计		

The above answers are true and correct to the best of my knowledge. I authorize any physician, medical institution, pharmacy, insurance company, employer, labor union, or association to release information to GBG/Tiecare International as is required to properly pay all benefits, if any, due me, my spouse, or family members of this claim. A photocopy of this authorization shall be considered effective and valid as the original.以上所填写的内容是在尽我所知的范围内正确并属实的。为了使我, 配偶及家人得到应获的保险理赔, 本人在此授权给任何医生、医疗机构、药店、保险公司、工会、雇主等相关单位, 提供给 GBG/Tiecare 国际公司任何与此保险理赔要求的相关资料。本批准书的影印件应被视为与原件同样有效。

_____ _____

Signature 签字 Date 日期

FRAUD NOTICE: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing false, incomplete or misleading information is guilty of a felony. 欺诈声明:任何有故意受伤，欺骗或欺诈保险公司，提供含有虚假信息、不完整信息或误导信息的索赔声明的都需要承担法律责任。