



索赔金额低于 1,600 元人民币(或等值的其他货币),如原始发票已清楚写明病症并列明费用明细, 请完整填写 A,B,C 栏。住院治疗或索赔金额高于或等于 1,600 元人民币(或等值的其他货币)的, 请完整填写 A, B, C, D, E 栏。请注意如果所需信息未按要求完整填写可能将造成理赔审核或赔款延迟。填写完毕后请与医疗费用收据原件、医疗费用明细清单原件、诊断病历原件一起提交。如索赔诊断性检验或非正规治疗的费用, 请同时提供您的治疗医师的书面介绍证明。不同的病症请分别填写理赔申请表。

All claims under ¥1,600 (or corresponding rates) per condition, please complete Section A, B and C and return this with the original receipt(s) showing the diagnosis and a full breakdown of costs for each condition being claimed for. All sections MUST be completed in full for hospitalization claims and all claims over ¥1,600 (or corresponding rates). Note that claims payment may be delayed if all required sections on the claim form are not completed in full. A referral letter from Your Specialist should be attached when you are claiming for diagnostic tests or covered alternative treatments.

保险单持有人 _____ 保险单号码 _____
Policyholder _____ Policy Number _____

栏目 A: 出险人详细资料 - 由被保险人/附带被保险人填写

Section A: Patient's Details - To be completed by the Insured/Supplementary Insured

姓: Surname:	住址及邮政编码: Address & Post Code:
名及英文字母简写: First Name & Initials:	身份证号/护照号码: ID No. / Passport No: 人民币付款且发票总额大于 1 万元人民币或等值一千美元的理赔, 以及所有外币付款理赔, 请提供相关护照或身份证件复印件。 Please attach your ID card/Passport copy if the claim amount is above RMB10,000 / USD 1,000 for RMB payment and for all Non-RMB payment.
出生日期(日/月/年): Date of Birth: Day Month Year	电邮: E-mail:
联系电话: Contact Telephone Number:	传真/移动电话: Fax/Mobile:
您是否有其他保险? Do you hold any other insurance? 是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes No 如果选择“是”, 请另用纸张详细说明。 If Yes, please provide full details on a separate sheet.	您本次索赔是否由于意外造成? Were your injuries caused by an accident? 是 <input type="checkbox"/> 否 <input type="checkbox"/> Yes No 如果选择“是”, 请另用纸张详细说明。 If Yes, please provide full details on a separate sheet.

栏目 B: 保险金给付信息 - 由被保险人/附带被保险人填写

Section B: Claims Settlement - To be completed by the Insured/Supplementary Insured

发生在中国大陆的相关费用:

Receiving Treatment inside mainland China:

索赔金额合计(保险金货币固定为人民币): Total amount claimed (currency of claim must be RMB):
保险金将转至您投保时所指定的银行账户。 Claim payment will be remitted to your designated bank account when you applied the coverage.

发生在中国大陆以外的相关费用:

Receiving Treatment outside mainland China:

索赔金额合计及货币种类: Total amount claimed, including currency of claim:
保险金给付币种: Currency in which you wish settlement to be made:

如保险金货币为‘人民币’, 保险金将转至您投保时所指定的银行账户。如您投保时未指定银行账户, 或给付币种为非‘人民币’时, 请完整填写如下信息:(银行账户必须为被保险人本人所有, 如为他人账户, 需被保险人另行授权指定)

If RMB has been chosen as settlement currency, claim payment will be remitted to your designated bank account when you applied the coverage. If no bank account designated before, or the currency you wish to settle is Non-RMB, please give full details in below blank. (The designated bank account must be under the name of the insured or else a separate authorization is needed)

注意事项: Notes: 1. 帐户名必须与开户名完全一致 Beneficiary name should be the same as bank account name. 2. 银行名称需完整, 包括分行/支行/分理处 Bank name should include branch name. 3. 给付货币为非人民币时, 须提供银行国际代码 For Non-RMB payment, Swift / IBAN / Sort Code is needed. 4. 给付货币为非人民币时, 需同时提供被保险人身份证/护照复印件 For Non-RMB payment, copy of passport/ID card of the insured is needed.	如果希望通过支票或银行转账方式收到您的保险金, 请认真填写您的开户银行详情如下: If settlement is to be sent care of your bank or by Transfer, please give full details of your bank below: 账户名: Beneficiary Name: 银行名称(含支行): Bank Name and Branch Name: 银行地址: Bank Address: 银行账号: Account Number: 国际代码: Swift/ IBAN/Sort Code:
领款通知书邮寄地址: Address to where settlement to be sent:	

请注意, 您接到本公司的通知时, 保险金可能尚未存入您的银行账户。请您向银行查询。

Please note payment may not have been credited to your bank account at the time you receive your Advice from Us. You will need to check with your bank.

栏目 C: 声明及授权 - 由被保险人/附带被保险人填写

Section C: Declaration - To be completed by the Insured/Supplementary Insured

“上述各项内容, 及本人提供的一切资料, 均完全属实。本人授权贵公司或其指定代表向任何第三方获取处理索赔的信息, 提供有关本人此次意外或疾病的一切资料及本人既往的健康状况、病历和诊疗资料。”

“I declare that all information, to the best of my knowledge, provided on this Claim Form is truthful and correct. I also understand that this declaration gives permission to China Life and their appointed representatives to approach any third party for information required to complete their assessment of this claim including, but not limited to, my current and previous Medical Practitioners.”

“本人允许贵公司在以下情况下使用、透露本人的个人信息 (包括在本表中填写的信息和其它途径收集到的信息) ①评估本次索赔或进行客户服务②因付款需要通知银行或信用卡公司③为贵公司或相关机构作与保险相关服务市场资料④处理索赔或保险研究使用。

“I declare and agree that the personal information collected or held by China Life, whether contained in this form or otherwise obtained may be used by China Life, or disclosed or transferred to any organization for the purpose to (1) assess this claim and to provide on-going insurance and customer services, (2) process and give effect to Credit Card Payment,(3) provide marketing material in respect of insurance related services of China Life or its associated companies and (4) process claims or analyze the insurance.”

“如保险金货币选择‘非人民币’, 本人委托贵公司办理以所给付的保险金金额为限的购汇业务”。

“If the chosen settlement currency is not RMB, I authorize China Life to purchase foreign exchange for claim reimbursement up to the policy benefit maximum.”

“对于发生在事先约定的医疗机构内, 针对特定的或保险公司已经事先担保的医疗服务项目, 我授权该医疗机构或指定的第三方代表我向保险公司提出理赔, 保险公司将直接付款至该医疗机构或指定的第三方。”

“For Direct Billing case or guaranteed case which the medical treatment received in the pre-appointed provider, I hereby authorize the provider or pre-appointed third party to directly bill my insurance company which should make payment of any benefit payable to the provider or pre-appointed third party.”

出险人签名: _____

日期: _____ 日 _____ 月 _____ 年

Patient's Signature:

Date: _____ Day _____ Month _____ Year

(如附带被保险人未滿 18 周岁, 还需法定监护人签名)

(If patient is under 18 years of age, Parent or Guardian must sign)

栏目 D: 索赔信息 - 由医生/牙医填写

Section D: Claims Information - To be completed by the Patient's Medical Practitioner or Dental Practitioner

本次意外或疾病的详细诊断和治疗过程: _____

Details of Medical Condition requiring Treatment: (Please provide the precise diagnosis, if known).

主要病因: _____

Underlying cause:

如系女性生育, 请告知怀孕是否属于任何方式的人工辅助妊娠: _____

If this claim is for maternity please advise whether the pregnancy is as a result of any form of assisted conception:

病情延续时间: _____

How long has this condition existed:

病人初次就医前何时发现病情或征兆: _____

When did the patient first become aware of any symptoms prior to seeking medical Advice?

病情首次就诊日期 (日/月/年): _____

Date of first consultation with any practitioner for this condition:

既往是否曾有相同或类似病情: _____

Has this, or any similar condition previously been suffered from?

预计治疗/诊断时间 (如果可知): _____

Please confirm the likely period of Treatment & prognosis (if known):

推荐病人前来就诊的医师的姓名和地址(如病人是由其他医生介绍):

Name & Address of referring Doctor/Dentist (Please complete only if the patient has been referred to You):

请另附本次病情的化验检查详细报告: _____

Please detail any diagnostic tests performed and attach the results:

本次治疗是否属于例行牙科检查 (仅由牙科医生填写)?

是 Yes 否 No

This question relates to Dental Treatment only is this claim for a routine check-up?

以上栏目如空间不足, 请另用纸张详细说明。

If you have insufficient space in any section, please provide full details on separate sheet

栏目 E: 医生/牙医详情 -由医生/牙医填写

Section E: Medical Practitioner or Dental Practitioner Details - To be completed by the Patient's Medical Practitioner or Dental Practitioner

医生姓名: Name of Practitioner:	盖章: Official Stamp
地址: Address	
电话: Tel:	
电邮: Email:	传真: Fax:
医生签名: Practitioner's Signature:	日期: 日 月 年 Date: Day Month Year

理赔申请注意事项:

INSTRUCTIONS FOR SUBMITTING A CLAIM:

****注意**** --为了保证您的索赔得到及时的处理, 请确认:

****IMPORTANT**** --This will ensure that your claim is reviewed in a timely fashion. Please ensure:

1. 所有医疗费用发票原件、药品处方、费用明细清单、诊断病历都已附在本表后。
All original receipts, prescriptions, breakdown and medical records are attached
2. 所有栏目都已按要求完整填写。
The Claim Form is completed in full
3. 声明和授权已签名并填写日期。
The declarations are signed and dated
4. 所有化验、检查报告已附于本申请表后。
All laboratory tests are attached
5. 诊断结果和主要病因已填写。
The diagnosis and underlying cause

重要提示: 请确保您的理赔申请表填写完整, 并在治疗发生后的两年内递交我公司。否则理赔申请表将会被退回, 并致您的理赔程序延迟。本公司将不会对任何由于填写理赔申请表及提供资料所引起的费用负责。本理赔申请表不作为本公司承担给付义务的证明。

Important Note - Please ensure Your Claim Form is completed in full and returned within two years of your initial treatment. Failure to complete your form in full will result in the form being returned to you and will hold up the processing of your claim. Please note China Life is not responsible for any costs associated with the completion of this form or for any further information/document requested by us to assess your claim. The issuing of this Claim Form is in no way an admission of liability.

为了使您获得更及时有效的理赔服务，任何非紧急的情况下的住院、日间治疗、核磁共振(MRI)、电脑断层扫描(CT)检查在就诊前建议您首先得到本公司或本公司医疗热线服务的书面允许（包括传真/电邮/信函等方式）。如有疑问，您可以拨打您会员卡上的医疗热线电话咨询。

Please ensure that all costs for non-emergency In-Patient/Day-Patient Treatment, all MRI & CT Scans, are agreed by us, or Our Helpline, in writing (Fax/Mail/Letter) before any planned Treatment is undertaken. Planned Treatment undertaken without pre-authorization from us will not be covered. A verbal confirmation does not constitute pre-approval. If in doubt, please contact the Medical Helpline, as shown on Your Membership Card.

注意：对不同病症的索赔请分别填写理赔申请书。

PLEASE NOTE: A SEPARATE CLAIM FORM MUST BE COMPLETED FOR EACH CONDITION CLAIMED.

住院及日间治疗

Planned In-Patient & Day-Patient Treatment

为了使您获得更及时有效的理赔服务，如拟接受医院住院或日间治疗，建议您遵循以下步骤进行：

In the event of a planned admission on an In-Patient or Day-Patient basis to a Hospital, the following steps must be taken. Payment of all expenses incurred by You will not be recoverable unless You follow these procedures.

1. 在医院住院或日间治疗之前，尽快拨打本公司医疗热线电话，通知我公司您的症状、将要进行的治疗方案、治疗项目和时间，以及就诊的医院和医生等详情。（本公司的医疗服务热线电话号码印制在您的会员卡背面）
Contact Our Medical Helpline as soon as reasonably possible prior to admission giving full details of the condition, proposed Treatment including dates and name of procedure (if known) together with the name of the Specialist and Hospital details. (The telephone number is provided on the back of Your membership card).
2. 本公司的医疗热线服务人员将确认您提供的信息是否完整或是否需提供进一步的信息。
The Medical Helpline will advise You if they have sufficient information to confirm Your cover. If not, they will advise You what further information is required.
3. 当您已提供了足够的信息后，本公司医疗热线服务人员将先口头确认我公司承担的基本保险责任，随后提交给您书面的证明。
When sufficient information has been made available to appraise Your claim, the Medical Helpline will verbally confirm the basis of Your cover and will dispatch written confirmation to You.
4. 本公司医疗热线服务人员将尽可能地为您的安排，直接由本公司将属于保险责任范围内的医疗费用支付给您的医院。此时您将无需支付医疗费用给医院。但该情况下请您在递交理赔申请表时，附上您从医院收到的未付的医疗费用的发票原件。
The Medical Helpline will attempt at all times to make arrangements with the Hospital for all eligible bills to be settled directly. Where this has been arranged You should send the original Claim Form and any unpaid invoices (if given to You by the Hospital) to Your China Life Claims Service.
5. 每人每次新的病症和不同的住院或留院观察请分别填写单独的理赔申请表。
Please ensure a new/separate Claim Form for each member, each new Medical Condition and each admission to Hospital is submitted.

门诊治疗

Outpatient Treatment

如果您在本公司指定的医疗网络范围以外进行门诊治疗，您须先支付全部医疗费用，然后再向本公司提交索赔申请。网络医院名单见：www.goodhealthworldwide.com。

If you receive medical Treatment as an Outpatient, outside of Our Provider Network Treatment must be paid for in full by you at the time of the appointment and re-claimed from us.

如发生上述情形，请确保您和您的医生完整无误地填写了理赔申请表。并将理赔申请表和索赔所需的支付凭证、处方、诊断书等资料（包括并不仅限于：医疗费发票原件、支付凭证、药品处方及医师的书面证明）提供给本公司。

In such circumstances please ensure that a Claim Form is completed by you and the Medical Practitioner or Specialist. Please remit this to your China Life Claims Service with all substantiating proof of your claim, including, but not limited to, the original invoice(s) and proof of payment, prescription and a written diagnosis from the Medical Practitioner.

请将您的理赔申请表递交给本公司康优理赔中心：

Please return your Claim Form to the following office:

康优全球医疗保险理赔中心

Goodhealth Claim Service

上海黄浦区西藏中路 18 号

港陆广场 1306B 单元

邮编：200001

传真：8621 6326 8525

理赔客服电话：

(86) 400 881 1269

+1 559 490 4958 (中国以外地区，对方付费)

电邮：chinaservices@goodhealthchina.cn

Unit 1306B, Harbour Ring Plaza,

18 Middle Xi Zang Rd,

Huang Pu District, Shanghai

Zip code: 200001

Fax: 8621 6326 8525

Claim Service Hotline:

(86) 400 881 1269

+1 559 490 4958 (collect, available worldwide)

Email: chinaservices@goodhealthchina.cn

www.goodhealthworldwide.com