永诚财产保险股份有限公司
ALLTRUST INSURANCE COMPANY OF CHINA LIMITED

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. Claims Services recommend claims to be submitted 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。理赔服务中心建议在治疗结束后起的（180）天内，尽快提交理赔申请。

*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
上海理赔中心：中国上海张杨路 707 号生命人寿大厦 3401 室 邮编 200120；
Tel 电话: (86-21)3126 9300; Fax 传真: (86-21)5835-3368; Email 电子邮件: aicclaims@gbg.com; Claim Status Inquiry 理赔状态查询: aicclaims@gbg.com

*GBG is a Claims Service Center authorized by Allturst Insurance
*GBG 是永诚保险授权的理赔服务中心

Policy holder (Primary Insured) Information
持保人 (主被保险人) 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 (Required) 电邮（必填）：	**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 主被保险人	
Name 姓名：	Date of Birth(Required) 出生日期（必填）：
Male 男 Female 女	Passport/ID 护照/身份证号：
Married 已婚 Single 单身	
Dependent Insured 附属被保险人	
Name 姓名：	Date of Birth(Required) 出生日期（必填）：
Male 男 Female 女	Passport/ID 护照/身份证号：
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? 如果附属被保险人年龄大于 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，必须具有从学校注册管理处开据的全职学生身份证明书。	
Is this patient also covered by: 申请人是否同时持有以下保险： Any other group health plan 其它团体健康保险 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 无过错汽车保险 If yes, provide name and address of other source: 如具有以上任何保险，请提供其名称及联系地址:	

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

Send by Wire Transfer 电汇付款：

Name of Bank 开户行支行名称：____

Name on Account 开户人姓名：____

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 银行开户行地址：____

Section B
第二部分

Medical records are necessary for claim reviewing. If there are no medical records, please ask doctor to fill out blank space of section B, put down his signature and have it stamped by the hospital. GBG will deem the information as valid medical information.
医学病历是理赔审核必须的材料。提交理赔申请时，若无法提供与就诊日期对应的详细病历，烦请医生协助填写第二部分，并签名及医院盖章后，可充当有效的医学信息。

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.
就我所知，以上内容属实。为了使我、配偶及家人得到应获的保险理赔，本人在此授权任何医生、医疗机构、药店、保险公司、工会、雇主等相关单位，将任何与此保险理赔要求的相关资料提供给 GBG/Tiecare。本批准书的影印件应被视为与原件同样有效。

________________________________ ______________________________

Primary Insured Signature 主被保险人签字 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:任何故意损害，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理赔申请都需要承担法律责任。