太平洋保险 CPIC

太平洋健康保险股份有限公司
Pacific Health Insurance Co.,Ltd.

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牙科治疗理赔申请书(非直付)
Non-Direct Billing Dental Claim Form

中文内容具有法律效力，英文翻译仅供参考。

Chinese text has legal effect and English translation is for reference only.

请勾选本次申请保单为： □ 团体承保 □ 个人承保

Type of coverage: □Group Insurance □Individual Insurance

注：若本次理赔金额小于10000元，带“▲”部分可不填写。

Note: If the claimed amount is less than RMB 10,000, columns with “▲” are optional.

被保险人基本信息

Basic Information of the Insured

姓 名 Name		性别 Gender		▲国籍 Nationality		▲职业 Occupation	
证件类型: □ 身份证 □ 护照 □ 其他 ID type: ID card Passport Others		证件号码 ID No.					
▲证件有效期 ID validity period	年 月 日 至 年 月 日 From YY MM DD to YY MM DD						
保单号码 Policy No.				预授权号 Pre-authorization No.			
联系电话 Tel		邮箱 E-Mail				邮编 Zip code	
联系地址 Contact address							

申请人基本信息（若申请人为被保险人本人，则无需填写）

Basic Information of the Claimant (Not required if the claimant is the insured)

姓 名 Name		性别 Gender		▲国籍 Nationality		▲职业 Occupation	
与被保险人关系 Relation with the insured	□父母 Parent; □配偶 Spouse; □子女 Child; □其他（请说明）Other (please indicate)________________________						
证件类型: □ 身份证 □ 护照 □ 其他 ID type: ID card Passport Others		证件号码 ID No.					
▲证件有效期 ID validity period	年 月 日 至 年 月 日 From YY MM DD to YY MM DD						
联系电话 Tel		邮箱 E-Mail				邮编 Zip code	
联系地址 Contact address							

注：申请人须为保险金受益人或其监护人.

Note: The claimant must be the beneficiary or the beneficiary’s guardians.

理赔申请项目及金额

Claims item and amount

费用类别填写参考 Guidance for type of expenses：1.紧急牙科 Emergency dental 2.预防治疗 Prevention 3.基础牙科治疗 Basic dental 4.重大牙科治疗 Major dental 5.其他类型 Others

诊治日期 Date of treatment	费用类别 Type of expenses	就诊医院 Hospital	就诊原因 Reason	收据数量 Number of receipts	是否原件 Original or not	发生金额（元） Claim amount (Yuan)
合计 Total：	索赔收据数量 Number of receipts：		张 piece:		索赔总金额 Total claim amount：¥	

其他申请材料Other application documents：

	原件 Original	复印件 Copy		原件 Original	复印件 Copy
□保单凭证 Insurance Certification	份	份	□授权委托书 Power of attorney	份	份
□患者身份证明 ID Of the patient	份	份	□疾病诊断书 Diagnosis statement	份	份
□处方 Prescription	份	份	□病理、血液 X 光报告 Pathological, blood test, and X-ray	份	份

			reports		
□医疗费结算明细清单 Itemized expense list	份	份	□病历、出院小结 Medical record or discharge summary	份	份
□受益人关系证明 Proof of relationship to the insured	份	份	□代理人身份证明 ID of the trustee	份	份
□意外事故证明 Certificate of accident	份	份	□银行卡或存折 Bank card or deposit book	份	份
□理赔申请表 Claims form	份	份	□其他 Others	份	份

出险信息-此处由诊疗医师填写

Medical information – to be completed by qualified dental practitioner

出险类型Type of event： □意外Accident □疾病Disease □其他Others		初诊日期（年/月/日）： Date of first treatment (YY/MM/DD)
初次就诊医院 Hospital for the first visit		本次病症初次发生日期（年/月/日）： Date of symptoms occurring for the first time (YY/MM/DD):
被保险人出险经过 Please describe the details of the event:		

请使用以下缩写填写牙科图表

Please fill in the dental chart with the abbreviations below:

	牙科图表Dental Chart															
	右 Right								左 Left							
治疗Treatment																
发现Finding																
上颌Upper jaw	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
下颌Lower Jaw	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38
发现Finding																
治疗Treatment																

Finding 发现

b=bridge 牙桥

gs=gingival swelling 牙龈肿胀

c=crown 牙冠修复

i=implant 植牙

ca/da/dn=caries/decay/dental necrosis 龋齿/蛀牙/牙齿坏

in-inlay 嵌体

m=missing tooth 牙齿缺失

cl=calculus 牙石

p=periodontis 牙髓炎

g=gap closure 间隙封闭

pu/od=pulpitis or odontitis 齿髓炎

gb=gingival bleeding 牙龈出血

gi=gingivitis 牙龈炎

Treatment 治疗

AF=amalgam 汞合金填充

O=orthodontics 齿列矫正

CF=composite 复合材料填充

ON=onlay 高嵌体

D=denture 假牙

OR=oral radiograph 口腔 X 光片

E=extraction 拔牙

PR=panoramic radiograph 全景 X 光片

I=implant 植牙

RB=replacement bridge 牙桥更换

IN=inlay 嵌体

gi=gingivitis 牙龈炎

RC=replacement crown 牙冠置换

M=metal ceramic crown 金属烤瓷牙冠

RCT=root canal treatment 根管治疗

NB=new bridge 新牙桥

S&P=scale and polish 去垢和抛光

NC=new crown 新牙冠

如果患者接受了NC, RC, IN或ON治疗，是否使用了贵金属或半贵金属？ □是Yes □否No
If the treatment was NC, RC, IN or ON, was precious or semi-precious metal used?
如果是，使用了哪种贵金属或半贵金属？
If yes, what precious or semi-precious metal has been used?

声明：本人声明在此理赔申请表上的陈述内容是完整、真实和无保留的。
Declaration: I declare that to the best of my knowledge and beliefs, the statements made on this form are full, true and complete.

诊疗医师签字：
Dental practitioner’s signature:

日期（年/月/日）：
Date (YY/MM/DD)

理赔保险金转账授权与声明（请务必完整填写以下所有信息内容）

Authorization and Statement for Claims Benefits Transfer (pls. be sure to complete the following table in its entirety)

本人授权贵司可将相关理赔款项直接转入本人填写的如下银行账户中（只能勾选一项）：

<table>
<tr><td colspan="4">I authorize your company to directly transfer the relevant claims payment to the designated bank account (tick one only):</td></tr>
<tr><td>□转个人银行账户
Transfer to personal bank account</td><td colspan="3">与被保险人关系 □本人；□受益人；□监护人；
Relationship with the insured: □Insured him/herself；□Beneficiary；□Guardian；</td></tr>
<tr><td>□转单位银行账户
Transfer to the employer's bank account</td><td colspan="3">勾选本项，即本人授权同意太平洋健康保险股份有限公司将本次理赔款转入投保单位的银行账户，由单位代为领取并转发至本人。
By ticking the box to the right, I authorize and agree that Pacific Health Insurance Co.,Ltd. shall transfer such claim payment to the bank account of the employer, which shall collect the claims payment and transfer the payment to the insured, the insured's guardian or the insured's beneficiary of death benefits.</td></tr>
<tr><td>开户银行
Bank name</td><td></td><td>详细信息
Details</td><td>________________分行_______________支行
Branch/Sub-branch</td></tr>
<tr><td>账户名
Account name</td><td></td><td>身份证件号码
ID No.</td><td></td></tr>
<tr><td>银行账号
Bank account</td><td colspan="3"></td></tr>
<tr><td colspan="4">**授权人声明：本人保证上述银行账户资料的真实、准确、有效。凡由本人提供的账户信息有误而导致的转账纠纷、由本授权引发的任何法律或经济纠纷，均由本人承担，与贵司无关。**
Authorizer's statement: I hereby guarantee that the bank account information provided above is truthful, accurate and valid. All transfer disputes arising from the wrong information provided above and any legal or economic disputes triggered by this authorization shall be undertaken by myself, which are irrelevant to your company.</td></tr>
</table>

反保险欺诈提示

Caution against Insurance Fraud

诚信是保险合同基本原则，根据相关法律规定，保险欺诈将承担以下责任：

The insurance contract is formed on the basis of integrity. According to relevant laws and regulations, those who have committed insurance fraud should bear the liabilities as follows:

【刑事责任】进行保险诈骗犯罪活动，可能会受到拘役、有期徒刑，并处罚金或者没收财产的刑事处罚。保险事故的鉴定人、证明人故意提供虚假的证明文件，为他人诈骗提供条件的，以保险诈骗罪的共犯论处。

[Criminal Liability] Those who are involved in criminal activities of insurance fraud will be subject to detention, fixed-term imprisonment along with criminal penalties of fining or property confiscation. An appraiser or certifier of an insured event who intentionally provides a false certificate for others to commit an insurance fraud shall be punished as the accomplice to insurance fraud.

【行政责任】进行保险诈骗活动，尚不构成犯罪的，可能会受到15日以下拘留、5千元以下罚款的行政处罚。保险事故的鉴定人、证明人故意提供虚假的证明文件，为他人诈骗提供条件的，也会受到相应的行政处罚。

[Administrative Liability] Those who are involved in activities of insurance fraud that do not constitute a crime will be subject to administrative penalties of detention within 15 days and a fine up to 5,000 Yuan. An appraiser or certifier of an insured event who intentionally provides a false certificate for others to commit an insurance fraud will be subject to the corresponding administrative penalty.

【民事责任】故意或因重大过失未履行如实告知义务，保险公司不承担赔偿或给付保险金的责任。

[Civil Liability] The insurance company shall not be liable for compensation or payment of insurance benefit in the event that the claimant withholds the truth intentionally or due to gross negligence.

授权与声明

Authorization and Statement

1. 本人声明以上陈述与回答全部属实，如有虚假，本人愿意承担法律责任。

I declare that the statements and answers above are true to the facts, and I am willing to undertake the legal liability for any false statement.

2、本人授权任何医疗机构、社保或农保机构、保险公司、公安机关、疾病防治中心等有关机构以及一切熟悉被保险人身体健康状况、相关事故的人士，均可将有关被保险人资料向中国太保{指中国太平洋保险（集团）股份有限公司及其直接或间接控股的子公司}或通过中国保险行业协会、中国保险信息技术管理有限责任公司、保险交易所及其合作伙伴等中国太保所委托的合作机构如实提供。本人愿意承担由此产生的一切法律后果。

I authorize all relevant institutions including medical establishments, social insurance or rural cooperative agencies, insurance companies, public security organs and centers for disease control and prevention and all persons familiar with the physical health

situation of the insured and relevant event to provide relevant information and materials of the insured truthfully to CPIC, which refers to China Pacific Insurance (Group) Co., Ltd and it direct and indirect controlled subsidiaries, through cooperative institutions entrusted by your company including the Insurance Association of China, China Insurance Information Technology Management Co., Ltd.(CIITC), insurance exchange and their partners. I am willing to undertake all the legal consequences arising therefrom.

3、本人同意贵司向中国保险信息技术管理有限责任公司报送本人的全部保单信息和理赔信息，并通过医疗机构、中国保险信息技术管理有限责任公司及知悉本人信息的其他机构查询与本人有关的承保、理赔、医疗等信息。

I agree that your company shall report all of my insurance policy and claim information to CIITC, and inquire about related underwriting, claim and medical information of myself through medical establishments, CIITC and other institutions aware of my personal information.

4、本人同意中国太保、中国保险信息技术管理有限责任公司基于为本人或保险公司提供服务的需要，可对上述信息进行必要的使用及与相关机构进行信息共享，但均应严格履行保密义务。

I agree that your company and CIITC can make necessary use of the information above and share such information with relevant institutions based on the need of your company and CIITC to provide services for me or insurance company, but such information must be kept in strict confidence.

5、在领取保险款项后，如有其他身故保险金受益人、法定继承人或法律规定享有保险金请求权的主体，就保险金与贵司发生争议或纠纷的，一切法律责任及费用由本人承担，与贵司无关。

Upon receipt of the claim benefits, in case of disputes or controversies over insurance benefit with your company by other beneficiary of death benefits, legal heir or subject entitled to the right to claim insurance benefit, all legal liabilities and expenses arising therefrom shall be undertaken by myself (the claimant), which shall be irrelevant to your company.

申请人签名： **申请日期：**

Signature of the claiman: **Date of application:**

授权委托书（申请人委托他人代为办理理赔事宜时需填写）

Power of Attorney (to be filled in when the claimant entrusts another person to handle the claim on his/her behalf)

本人现委托_________________先生/女士前往太平洋健康保险股份有限公司代为办理理赔事宜。

I hereby entrust Mr./Ms. _________ to handle the matters regarding the claim on my behalf with Pacific Health Insurance Co.,Ltd. (herein referred to as “your company”).

受托人信息 Trustee information	姓名 Name		性别 Gender		▲国籍 Nationality		▲职业 Occupation	
	证件类型 ID Type		证件号码 ID No.					
	▲证件有效期 ID validity period	年 月 日至 年 月 日 From YY MM DD to YY MM DD				联系电话 Tel		
	联系地址 Contact address						邮编 Zip code	
	与申请人关系： □业务员 □亲属 □朋友 □其他________ Relation with the applicant: □Salesperson □Relative □Friend □Other________							

具体代理权限 Specific scope of power of attorney：

□递交理赔申请资料 Submit claims application materials；

□领取理赔申请资料退件 Collect claims application materials returned；

□领取理赔款（请说明授权委托原因并填写以下账户信息）Collect claim payment (*pls. provide the reasons for authorization and fill in the following tables for account information)：

开户银行 Bank name		详细信息 Details	________分行________支行 Branch/Sub-branch
银行账号 Bank account			

<table>
<tr><td colspan="2">委托人声明：在办理以上理赔事务过程中，本人所指定的开户行、开户名、账号以及受托人所作的相应文书及签字皆代表本人的真实意思表示，如因本授权不实等原因引致的与本授权书有关的法律后果由本人承担全部责任。本授权的有效期限到受托人办理完毕以上事务时止。
Declaration of the trustor: While handling matters regarding the above claim, the bank name, account name, and bank account designated by myself and the corresponding documents and signatures made by the trustee all represent my true intention. All legal consequences arising from any false statement in this power of attorney shall be undertaken by myself. The term of this power of attorney shall expire till the completion of claim settlement by the trustee.</td></tr>
<tr><td>委托人签名：
Signature of the trustor:

日期：
Date:</td><td>受托人签名：
Signature of the trustee:

日期 ：
Date:</td></tr>
</table>

请将完整的理赔申请表原件及相关理赔资料邮寄至：上海市杨浦区大连路 688 号宝地广场 A 座 25 层 01A 单元

太平洋健康保险股份有限公司理赔部（收） 邮 编 200082 保险服务热线：10108686

Please send the original claim forms and relevant claim documents to: Claims Dept. of Pacific Health Insurance Co.,Ltd., 01A, 25/F, BaoLand Plaza Unit A; No.688, Dalian road, Yangpu District Shanghai 200082 P.R. China