

医疗理赔申请书(非直付)

Non-Direct Billing Medical 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: D type:	<input type="checkbox"/> 身份证 ID card	<input type="checkbox"/> 护照 Passport	<input type="checkbox"/> 其他 Others	证件号码 ID No.			
保单号码 Policy No.				预授权号 Pre-authorization No.			
联系电话 Tel				邮箱 E-Mail			
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	<input type="checkbox"/> 父母 Parent; <input type="checkbox"/> 配偶 Spouse; <input type="checkbox"/> 子女 Child; <input type="checkbox"/> 其他 (请说明) Other (please indicate)						
证件类型: ID type:	<input type="checkbox"/> 身份证 ID card	<input type="checkbox"/> 护照 Passport	<input type="checkbox"/> 其他 Others	证件号码 ID No.			
▲证件有效期 ID validity period	From	年 YY	月 MM	日 DD	to	年 YY	月 MM
联系电话 Tel				邮箱 E-Mail			
联系地址 Contact address							

注: 申请人须为保险金受益人或其监护人; 身故保险金受益人为多人时, 受益人需填写“多受益人授权委托书”。

Note: The claimant must be the beneficiary of insurance or his/her guardians; when there are multiple beneficiaries of death benefits, the beneficiaries are required to fill in the Power of Attorney for Multiple Beneficiaries.

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. 门急诊 Outpatient and emergency care 2. 住院 Inpatient care 3. 门诊大病 Outpatient care for critical illness 4. 生育 Maternity care 5. 眼科 Vision care						
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:			退回原件 Return original copies		<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	
	原件 Original	复印件 Copy				原件 Original
<input type="checkbox"/> 保单凭证 Insurance Certification	份	份	<input type="checkbox"/> 授权委托书 Power of attorney			份

<input type="checkbox"/> 患者身份证明 ID Of the patient	份	份	<input type="checkbox"/> 疾病诊断书 Diagnosis statement	份	份
<input type="checkbox"/> 处方 Prescription	份	份	<input type="checkbox"/> 病理、血液 X光报告 Pathological, blood test, and X-ray reports	份	份
<input type="checkbox"/> 医疗费结算明细清单 Itemized expense list	份	份	<input type="checkbox"/> 病历、出院小结 Medical record or discharge summary	份	份
<input type="checkbox"/> 受益人关系证明 Proof of relationship to the insured	份	份	<input type="checkbox"/> 代理人身份证明 ID Of the trustee	份	份
<input type="checkbox"/> 意外事故证明 Certification of accident	份	份	<input type="checkbox"/> 银行卡或存折 Bank card or deposit book	份	份
<input type="checkbox"/> 理赔申请表 Claims form	份	份	<input type="checkbox"/> 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 medical practitioner

出险类型Type of incident: <input type="checkbox"/> 意外Accident <input type="checkbox"/> 疾病Disease <input type="checkbox"/> 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:	

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）： I authorize your company to directly transfer the relevant claims payment to the designated bank account (tick one only):	
<input type="checkbox"/> 转个人账户 Transfer to personal bank account	与被保险人关系 <input type="checkbox"/> 本人； <input type="checkbox"/> 受益人； <input type="checkbox"/> 监护人； Relationship with the insured: <input type="checkbox"/> Insured him/herself; <input type="checkbox"/> Beneficiary; <input type="checkbox"/> Guardian;
<input type="checkbox"/> 转单位银行账户 Transfer to the employer's bank account	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。勾选本项需提供《保险金对公转账授权书》。 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. By ticking this box, you shall provide the Power of Attorney for Transfer to Corporate Account.
开户银行 Bank name	详细信息 Details
账户名 Account name	身份证件号码 ID No.
银行账号 Bank account	_____分行_____支行 Branch/Sub-branch
<p>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.</p>	

反保险欺诈提示

Caution against Insurance Fraud

<p>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:</p> <p>【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.</p> <p>【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。</p>
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[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（以中国太保官网信息披露为准）】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 its direct and indirect controlled subsidiaries (subject to the publicly disclosed information of CPIC official website), or through cooperative institutions entrusted by CPIC 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收集处理被保险人/申请人/领款人姓名、性别、证件类型、证件号码、联系电话、地址、国籍/职业/证件有效期、理赔事项信息、金融账户、就诊信息、病例、发票信息，用于准确识别本人投保信息和申请理赔的需要，但均应严格履行保密义务。

I agree that your company and CIITC collect and process the information of the name, gender, ID type, ID No., contact telephone No., address, nationality/occupation/ID validity period and medical information of insured for the purpose of identifying correctly the insurance application information of myself and filing for claim, 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（正楷）：

Signature of the claimant (Regular script) :

申请日期：

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	姓名 Name		性别 Gender		▲国籍 Nationality		▲职业 Occupation	
	证件类型		证件号码					
information	ID type		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： Relation with the applicant:	<input type="checkbox"/> 业务员 <input type="checkbox"/> 亲属 <input type="checkbox"/> 朋友 <input type="checkbox"/> 其他（请写明与申请人关系）____ <input type="checkbox"/> Salesperson <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Other(pls. indicate the relationship with claimant)_____						

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） Collect claim payment (*pls. provide the reasons for authorization):

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

委托人声明：在办理以上理赔事务过程中，本人授权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 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.

委托人签名（正楷）：
Signature of the trustor(Regular script) :

日期：
Date:

受托人签名（正楷）：
Signature of the trustee(Regular script) :

日期：
Date:

保险服务热线：4008695500
Insurance service hotline: 4008695500

公司网址：http://health.cpic.com.cn
Company website: http://health.cpic.com.cn