中国平安 PING AN
专业 · 价值

平安健康保险股份有限公司
PING AN HEALTH INSURANCE COMPANY OF CHINA, LTD.

* H C 0 1 0 *
单证代码 Document code: 000000NK1302

理赔申请书
Claim Application Form

该理赔申请书适用于**医疗费用、 津贴、 重大疾病等的理赔申请。**
Use this form to apply for reimbursement of **medical expenses, allowance and critical illness policies, etc.**

请填写本申请书并附上以下材料（最终材料要求以保险公司通知为准）

- 被保险人的**有效身份证明文件**复印件;
- **医疗费用收据(发票)原件及费用明细清单;**
- **病历资料、处方**(如有)、**出院小结**(住院理赔申请)复印件;
- **银行账户信息**复印件(如果该帐户信息第一次使用)

1.身故申请需提供死亡证明和户口注销证明复印件
2.伤残申请需提供残疾鉴定证明复印件
3.意外申请需提供意外事故证明

邮寄地址、详细理赔材料要求等可登录health.pingan.com查询
若您有任何问题，请电话联系我们：95511选7（中文）

Please fill in this application form and attach the following materials (final material requirements are subject to insurer's notice)

- A copy of the insured's **valid identification;**
- **Original invoice(s)/receipt(s) ("fapiao") and itemized medical bills;**
- A copy of the **medical records, prescription** (if any), **discharge summary** (for inpatient claims);
- A copy of the **Bank account statement** for claims reimbursement (if we are using these bank details for the first time).

1. For a death claim, copies of the death certificate and the certificate of cancellation of household registration are required
2. For a disability claim, a copy of the disability identification certificate is required
3. For an accident claim, the proof of the accident is required

The mailing address and detailed claim material requirements can be found on health.pingan.com
If you have any questions, please feel free to contact us by phone at 400 8833 663 Option 2 (English)

1、出险者信息 Details of the Insured

出险者姓名 Full name			
证件类型 ID type	☐ 身份证 ID card ☐ 护照 Passport ☐ 其他 Other _____		
证件号码 ID number			
证件有效期至 ID expiry date	YYYY/MM/DD	国籍 Nationality	
职业 Occupation		性别 Gender	☐ 男Male ☐ 女Female
投保单位（公司名称） Policy holder (company name)	个人客户无需填写 If you are insured as an individual, you do not need to complete this field		

分单号 Sub-policy number	
联系电话 Telephone number	
邮政编码 Post code	
电子邮箱 Email address	@
邮寄地址 Postal address	

2、申请人信息 Details of the Applicant

如申请人非出险者本人请填写如下信息
Only to be completed if the person filling in this form is NOT the insured

申请人姓名 Applicant's name			
证件类型 ID type	☐ 身份证 ID card ☐ 护照 Passport ☐ 其他 Other _____		
证件号码 ID number			
证件有效期至 ID expiry date	YYYY/MM/DD	国籍 Nationality	
职业 Occupation		性别 Gender	☐ 男Male ☐ 女Female
申请人是出险者的 The applicant is the insured's	☐ 父母 Parent ☐ 子女 Child ☐ 配偶 Spouse ☐ 其他 Other _____		
联系电话 Telephone number			
邮政编码 Post code			
电子邮箱 Email address	@		
邮寄地址 Postal address			

3、事故信息 Details of the Event

事故类型 Type of clain	☐ 疾病医疗费用 Medical expense of disease ☐ 意外医疗费用 Accidental medical expense ☐ 津贴 Allowance ☐ 重大疾病 Critical illness policy ☐ 伤残 Disability insurance benifits ☐ 身故 Death insurance benefits ☐ 其他 Other _____
事故日期 Date of event	YYYY/MM/DD
是否为本次疾病首次就诊 Is this the first visit (or inclusive of the first visit) for this condition?	☐ 是 Yes ☐ 否 No
首诊医院 Hospital of first treatment	
出险人是否在其他保险公司投保人身保险 Whether the insured has life insurance policy in another insurance company	☐ 是 Yes ☐ 否 No

保险公司名称 Company name	

就诊日期 Date of treatment （年/月/日 YYYY/MM/DD）			
费用类别 Expense type	☐ 门诊 OP ☐ 住院 IP		
费用金额 Amount		货币单位 Currency	
发票张数 Number of invoices			
主要病情及诊断 Key symptoms and diagnoses			
提交发票总数 Tatel number of invoices submitted			
申请理赔金总额 Total amount			

就诊日期 Date of treatment （年/月/日 YYYY/MM/DD）			
费用类别 Expense type	☐ 门诊 OP ☐ 住院 IP		
费用金额 Amount		货币单位 Currency	
发票张数 Number of invoices			
主要病情及诊断 Key symptoms and diagnoses			
提交发票总数 Tatel number of invoices submitted			
申请理赔金总额 Total amount			

如行数不够可用该格式添加附页填写
If you require more space, please add additional pages to this form, in the same format.

4、保险金给付信息 Details for Benefit Payment

理赔金仅能给付被保险人、被保险人的受益人、被保险人的法定监护人及授权第三方。理赔金仅通过转账给付，请提供有效的人民币账户信息，如为外币结算案件，理赔金将按首诊日汇率转换为人民币予以给付。

Claims will only be reimbursed into the bank account of the insured, the beneficiary of the insured, the legal guardian of the insured or an authorized third party. Claim reimbursements will only be made by bank transfer in Renminbi into a valid bank account. If the claim is in a foreign currency, payment will be made at the exchange rate at the earliest date on the invoice.

理赔金领取 Payment options	以下账户信息用于本次理赔金给付(该账户信息第一次使用， 请提交账户信息复印件) Use the bank details provided below for this claim reimbursement (Please submit proof of these bank details when using the bank details below for the first time)	
账户信息 Bank Details	户名 Account Name	
	银行名称 BankName	
	开户分行 Branch	
	账号 AccountNumber	

个人声明

1. 本人确认理赔申请书上所填写的内容真实详尽。

2. **本人同意将本次理赔申请的保险金转入本次申请确认的本人银行账户或授权的第三方银行账户，由该账户所有人代为领取保险金，因本人或申请人过错导致转账错误、转账不成功、未及时或未全额收取理赔款的，贵公司不承担责任。**

3. 本人同意：从本次理赔的保险给付金中扣除尚未偿还的不属于保险责任范围内的费用，包括但不限于以下场景：保险公司已为本人向医院垫付的费用、保险公司已为本人预先赔付的费用、保险公司发现既往案件中不属于保险责任范围内的费用等。

客户个人信息授权声明：

一、为申请理赔及理赔调查之所需，被保险人同意并授权：

（一）为准确识别本人投保信息之所需，本人同意并授权平安健康险收集本人的**姓名、证件类型、证件号码、**证件有效期限、性别、**手机号、联系地址、金融账户信息、**与投保人及领款人的关系、有无社保、国籍、**职业、工作单位、婚姻状态、医疗健康信息、涉税信息、家庭财产信息、人脸及声音信息、保单信息、投保理赔记录、既往病史、体检信息；**

（二）平安健康险向其合作机构（查询路径：平安健康险官方网站-理赔服务-理赔常用表格及文件下载（平安健康险合作机构））提供本人的**姓名、证件类型、证件号码、保险合同、理赔申请书、病历资料和检查报告；**

（三）平安健康险及其合作机构向任何知悉与本次理赔服务有关的本人身体健康及其他情况的行政司法机关、公安部门、司法鉴定中心、国家金融监督管理总局及其派出机构、人社相关机构、社会医疗保险机构、体检机构、医疗机构、商业保险机构及其它单位或人员提供本人的**姓名、证件类型、证件号码、保险合同、理赔申请书；**

（四）任何知悉与本次理赔服务有关的本人身体健康及其他情况的行政司法机关、公安部门、司法鉴定中心、国家金融监督管理总局及其派出机构、人社相关机构、社会医疗保险机构、医疗机构、体检机构、 商业保险机构及其它单位或人员将其知悉的**本人发生的保险事故的具体信息、保单信息、投保理赔记录、就诊医院、职业、诊断证明、病历信息、就诊费用、发票号、体检信息、既往病史信息**提供给平安健康险及其合作机构；

（五）平安健康险的合作机构对本人投保、承保、理赔、医疗、健康服务等阶段的信息进行必要加工、使用，并将与风险控制有关的信息处理结果回传给平安健康险用于理赔调查；

二、前述加黑加粗信息属于您的敏感个人信息，一旦泄露或者被非法使用可能导致您的人身、财产安全受到危害。如您不同意我们处理（包括收集、存储、对外传输、提供、委托处理等）该信息，可能无法使用我们提供的理赔服务。

三、如我们处理的个人信息涉及不满14周岁的未成年人个人信息，我们会将其个人信息作为敏感个人信息进行处理，并按照相关法律法规予以保护。

四、在对外传输、提供、委托处理您的信息前，我们会事先进行个人信息保护影响评估并对要求其按照法律法规、本政策以及其他任何相关的保密和安全措施来处理您的个人信息。

Declaration

1. I declare that all information provided on this Claim Application Form and the documents submitted with it are true and accurate to the best of my knowledge.
2. **I agree that reimbursement for this claim will be made into the bank account of the insured or into the bank account authorized on this application, and that the account holder is entitled to receive the reimbursement. Ping An Health will not be responsible for errors or failed, delayed or incomplete payments due to mistakes on the application form or having the incorrect bank account details.**
3. I agree that any payments made by the insurer that are not covered by my policy and have not been repaid will be deducted from the benefits of this claim. This includes but is not limited to, the following situations: advance hospital payments made by the insurer on my behalf, advance claim payments, and any expenses identified by the insurer in prior cases that are not covered under the insurance policy.

Clauses on Individual Information Authorization:

i. For the purpose of claims application and claims investigation, the Insured allows and authorizes:

(1) In order to accurately identify my personal information of insurance application, I allow and authorize PAH to collect **my name, ID type, ID number,** ID expiration date, gender, **cell phone number, address, financial account information,** relationship with the Insured, whether I have social health insurance or not, nationality, **occupation, company, marital status, medical and health information, tax-related information, household property information, face and voice information, policy information, claims history, pre-existing conditions, and health checkup information;**

(2) PAH to provide its partners with **my name, ID type , ID number, insurance contract, claim application form, medical records and inspection report** (search pathway: PAH's official website - Claims services - Download of common claims forms and documents (PAH's partners);

(3) PAH and its partners to provide **my name, ID type, ID number, insurance contract and claim application form** for any administrative and judicial organs, public security departments, judicial expertise centers, national financial regulatory administration and its branches, human resources and social security authorities, social health insurance agencies, health checkup centers, medical institutions, commercial insurers and other units or persons that are aware of my health and other information related to this particular claim service;

(4) Any administrative and judicial organs, public security departments, judicial expertise centers, national financial regulatory administrationand its branches, human resources and social security authorities, social health insurance agencies, medical institutions, health checkup centers, commercial insurers and other units or persons that are aware of my health and other information related to this particular claim service to provide the information they are aware of for PAH and its partners, including the **information of my insurance accident, insurance policy, claims records, hospitals, occupation, diagnosis certificates, medical records, medical expenses, invoice number, health checkup results, and pre-existing conditions;**

(5) PAH's cooperative institutions shall process and use the information of the applicant in the stages of insurance, underwriting, claim settlement, medical treatment and health service, and shall return the processing results related to risk control to PAH for claim investigation

ii. The aforementioned information in bold and black is your sensitive personal information, which, if disclosed or illegally used, may cause your personal and property safety to be jeopardized. If you do not agree to our processing (including collection, storage, transmission, provision, and entrusted processing) of such information, you may not be able to use the claims services provided by us.

iii. If the personal information we process involves the personal information of minors under the age of 14, we will treat their personal information as sensitive personal information and protect it in accordance with relevant laws and regulations.

iv. Before transmitting, providing or entrusting the processing of your information, we will assess the impact on the protection of personal information in advance and request the processing of your personal information in accordance with the laws and regulations, the policy, and any other relevant confidentiality and security measures.

本人已阅读并确认本理赔申请书中所有声明及授权事项
I have read and accept the Declaration and Authorization details above

***备注:本单证中申请授权第三方代为领取理赔金仅限于连带被保险人之间，并需同时提供双方身份证明材料**
•Note: In order for the insured to authorize a member on the same sub-policy to receive the reimbursement, both the insured and the account holder must sign below and submit copies of their ID documents together with this form.

出险者（被保险人/委托人）签名 _____ **日期 Date：** YYYY/MM/DD
Signature of the Insured (Insured /Principal)

申请人（监护人/被委托人）签名 _____ **日期 Date：** YYYY/MM/DD
Signature of the Applicant (Guardian/Attorney)

仅供公司填写 For office use only

保险公司签收人签名 _____ **日期 Date：** YYYY/MM/DD
Signature of recipient at Ping An Health

反保险欺诈提示

诚信是保险合同基本原则，涉嫌保险欺诈将承担以下责任。

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。

行政责任进行保险诈骗活动，尚不构成犯罪的，可能会收到15日以下拘留、5000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。

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。

Anti-Fraud Notice

This insurance agreement is formed on the basis of integrity. Any suspicion of insurance fraud will carry the following liabilities.

Criminal liabilities Any criminal activities involving insurance fraud can lead to: detention, imprison ment and other penalties such as a fines or confiscation of personal property. Appraisers or witnesses of an incident who intentionally provide false documents or information to allow others to defraud the insurer

will be treated as accomplices in the insurance fraud.

Administrative liabilities Those who conduct insurance fraud that does not constitute a crime will be subject to administrative punishment such as detention of up to 15 days or a fine of up to RMB 5 000. Appraisers or witnesses of an incident who intentionally provide false documents or information to allow others to defraud the insurer will be treated as accomplices in the insurance fraud.

Civil liabilities If an applicant fails to provide true statements, either intentionally or due to gross negligence, the insurer will not reimburse or pay insurance benefits.