中国平安 PING AN
金融 · 科技

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

医疗理赔申请书
Claim Application Form for Medical Expenses

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

请填写本申请书并附上以下材料：
- 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）

如为团体保单，请提交给您的人力资源联络人或您保单的服务人员（邮寄地址可登陆health.pingan.com查询）
如为个人保单，请提交给您的销售代理人
若您有任何问题，请电话联系我们：95511 选7（中文）

Please complete the form and attach the following:
- 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).

For group policies, submit to your HR contact person or post it to your account manager (addresses can be found at health.pingan.com).
For individual policies, submit to your sales agent
If you have any queries, please contact us by phone: 400 8833 663 Option 2 (English)

1、出险者信息 Details of the Insured

出险者姓名 Full name		证件有效期至 ID expiry date	YYYY / MM / DD
证件类型 ID type	☐ 身份证 ID card ☐ 护照 Passport ☐ 其他 Other _____	国籍 Nationality	
证件号码 ID number		职业 Occupation	
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	性别 Gender	☐ 男 Male ☐ 女 Female
分单号 Sub-policy number			
联系电话 Telephone number	电子邮箱 Email address	@	
邮政编码 Post code	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		证件有效期至 ID expiry date	YYYY / MM / DD
证件类型 ID type	☐ 身份证 ID card ☐ 护照 Passport ☐ 其他 Other _____	国籍 Nationality	
证件号码 ID number		职业 Occupation	
申请人与出险者关系 Relationship of the applicant to the insured	☐ 父母 Parent ☐ 子女 Child ☐ 配偶 Spouse ☐ 其他 Other _____	性别 Gender	☐ 男 Male ☐ 女 Female
联系电话 Telephone number	电子邮箱 Email address	@	
邮政编码 Post code	邮寄地址 Postal address		

3、事故信息 Details of the Event

事故类型 Type of claim	☐ 医疗费用 Medical expense ☐ 住院津贴 Inpatient allowance ☐ 重大疾病 Critical illness policy					
事故日期 Date of event	YYYY / MM / DD					
是否为（含）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				
就诊日期 Date of treatment（年/月/日 YYYY/MM/DD）	费用类别 Expense type		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
	门诊 OP	住院 IP				
	☐	☐				
	☐	☐				
	☐	☐				

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.

提交发票总数 Total number of invoices submitted		申请理赔金总额 Total amount	

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 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	☐ 使用已留存于平安健康险的账户信息（勾选此项，则无需填写以下账户信息或提交账户信息复印件）。 Use the bank details already recorded by Ping An Health for this claim reimbursement (if this option is selected, you do not need to complete the bank details below or submit proof of bank details) ☐ 以下账户信息用于本次理赔金给付（勾选此项，且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 (if this option is selected, and we are using the bank details below for the first time, submit proof of these bank details)			
账户信息 Bank Details	户 名 Account Name			
	银行名称 Bank Name		开户分行 Branch	
	账 号 Account Number			
授权保险公司留存，供后续理赔给付使用 May Ping An Health record these bank details for future claim reimbursements?	☐ 是 Yes ☐ 否 No			

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：从本次理赔的合理保险给付金中，扣除尚未偿还的不属于保险责任范围但保险公司已为本人向医院垫付的医疗费用。

客户个人信息授权声明

1. 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保险股份有限公司（下称“平安健康保险”）收集**报案人/投保人/被保险人的姓名、证件类型、证件号码、性别、手机号、地址、账户信息、与被保险人的关系**等必要信息。
2. 为申请理赔之所需，本人同意并授权平安健康保险及其合作的医疗机构、药店等第三方机构收集、共享被保险人的理赔申请相关资料，包括但不限于**出险描述、所在医院、职业、诊断证明、病历信息、就诊费用、发票号**等信息。
3. 为进行理赔调查之所需，本人授权上海保险交易所股份有限公司及其医疗合作伙伴（下称“信息收集方）根据平安健康保险开展精准核保、风险防控服务的申请，向合法持有与本次理赔相关的本人及被保险人健康信息的机构查询相关健康信息并提供给平安健康保险，可查询的健康信息仅限于**医疗记录、体检信息、既往病史**。平安健康保险与信息收集方将对查询的健康信息严格保密，未经本人授权同意，不得向其他第三方提供、泄露。
4. 本人知晓并同意，如本人拒绝提供上述信息，平安健康保险股份有限公司将无法确认本人的身份及保单信息以完成相关理赔手续。本授权声明未尽事宜按照投保时《隐私政策》及相关附属规则予以履行。

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 the medical expenses that Ping An Health has already paid to the hospital, and which are not covered by my insurance policy, will be deducted from the benefit payment for this claim.

Clauses on Individual Information Authorization

1. I agree and authorize Ping An Health Insurance Company of China, Ltd. (hereinafter referred to as "Ping An Health") to collect the necessary information such as the **name, ID type, ID number, gender, mobile number, address, account information and relations with the insured of the claimant/ policy holder/ the insured**, for the purpose of accurately identifying my insurance information.
2. I agree and authorize Ping An Health and its partner medical institutions, pharmacies and other third-party institutions to collect and share relevant materials of the insured's claim application, including but not limited to **incident descriptions, hospitals, occupations, certification of diagnosis, medical record information, medical expenses, and invoice number**, for the purpose of claim application.
3. I authorize Shanghai Insurance Exchange Co., Ltd. and its medical partners (hereinafter referred to as "information collectors"), for the purpose of claim investigation, to query relevant health information from the institution that legally holds the insured's and my health information related to the claim, and provide it to Ping An Health, according to Ping An Health's application for conducting accurate underwriting and providing risk prevention and control services. The health information that can be inquired is limited to **medical records, health check-up information and past medical history**. Ping An Health and the information collectors shall keep the health information inquired strictly confidential and may not provide or disclose it to other third parties without my authorization and consent.
4. I understand and agree that, if I refuse to provide the above information, Ping An Health will not be able to confirm my identity and insurance information to complete relevant claim procedures. Matters not mentioned in this authorization declaration shall be performed in accordance with the Privacy Policy and relevant pertaining rules at the time of insurance application.

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 Signature of the Insured (Insured / Principal) _____ 日期 Date: YYYY / MM / DD

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

仅供公司填写 For office use only

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

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, imprisonment 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.