Worldwide Health Plan Claim Form
医疗保险索赔单

Please mail this form and ORIGINAL invoices to：请将此理赔表格连同原始账单邮寄到：

ERV (China) Travel Service and Consulting Ltd.,
Unit 1103A, Shun Tak Tower, No 1 Xiangheyuan Road,
Dongcheng District, Beijing 100028 P.R.China

欧乐旅行援助(北京)有限公司
中国北京市东城区香河园路 1 号信德京汇中心 1103A 单元
邮编： 100028

Insured's Personal information **被保险人个人信息**	Name 姓名	Policy No. 保单号	
	Insurance Card Number 保险卡卡号	E-mail 电子邮件	
	Mailing address 邮寄地址		Tel. 电话
Compensation claimed (please attach original documents) **赔偿申请** (请附上原始账单)	**Expenses incurred on the account of the illness/injury?与伤/病相关的费用**	**Currency** **币种**	**Amount** **金额**
Payment Bank Account **付款银行账户**	Bank name 银行名称		
	Bank Address （Pls specify to the branch） 银行地址 （请具体到支行）		Account holder 户名
	Bank account No. 账号		
Signature **签名**	I hereby accept that the Insurance Company or the Assistance Provider appointed by the insurance company procures information about the state of my health with a view to obtaining the information necessary for the evaluation of the insurance event and for the assessment of the claim. My acceptance comprises medical reports from the date of which the policy came into force and until the final assessment date of the benefit, and any other supplementary medical records that may be deemed necessary by the Insurance Company or the Assistance Provider for the purpose of evaluating issuance event or assessing claims. The reports can be procured from the health care sector, hospitals and healthcare institutions, public authorities, insurance companies and pension funds. Other insurance companies, pension funds and other authorized persons within the health care sector, involved in the case, are allowed to become acquainted with the medical records procured. I hereby authorize the Insurance Company via its appointed Assistance Provider ERV (China) Travel Service and Consulting Ltd. to act on my behalf and settle payments directly with hospitals, clinics and other service providers. By this authorization I furthermore accept that the insurance payments for said services will be paid directly from the Insurance Company via the Assistance Company to the service providers. 本人在此同意，“保险公司”或其指定的“救援服务公司”为评估本人保险事宜及核定保险索赔之目的，有权获得有关本人健康状况的信息，包括自保单生效之日起至保险权益的最终核定之日止的医疗记录，及“保险公司”或其指定的“救援服务公司”在评估、核定过程中认为必要的其他补充性医疗记录。 记录可从医疗部门、医院、医疗机构、公众权威机构、保险公司和养老基金那里获得。 其他保险公司、养老基金、医疗部门及其他经授权人士，凡与本人保险事宜有关的，亦有权了解所取得的医疗记录。 本人在此授权“保险公司”经其指定的“救援服务公司” 即“欧乐旅行援助（北京）有限公司 ERV (China) Travel Service and Consulting Ltd.”代表本人直接与医院、诊所、和其他服务机构进行交涉并直接付款。在此授权中，本人进一步同意，有关该等服务的保险付费，将由“保险公司”经“救援服务公司”直接支付给服务机构。 Applicant's signature 申请人签名 Date 日期 _____ _____		

To be completed by the treating doctor in English or Chinese or alternatively please attach the original diagnosis and prescription

以下由主治医生用正楷中文或英文填写或者附原始病历及药方

Medical provider information **医疗提供方信息**	Name of Doctor 医师姓名	Qualifications 职称	
	Name of hospital 医院名称	Tel. 电话	
	Address 地址		E-mail address 邮箱
Medical Information **医疗信息**	Has treatment guaranty been obtained? 是否收到付款保证？	Yes 是 ■	No 否 ☐
	Has treatment been received for similar illness before? 以前是否因为相似疾病接受过治疗？ If yes, please indicate first date. (dd/mm/yyyy) 如果是，请指出首先接受治疗的日期。（日/月/年）	Yes 是 ☐	No 否 ☐
Details of treatment **治疗详情**	Please provide full details of the medical condition requiring treatment, including the ICD-Code 9 or 10 (International Classification of Disease) 请提供需要接受治疗的病情，包括 ICD 编码 9 或者 10。		
Doctor's signature **医师签名**	（签名或者签章） Date （dd/mm/yyyy） 日期（日/月/年）		