cigna healthcare
招商信诺
保险 · 健康 · 财富

High-end Medical Insurance Claim Form
高端医疗险理赔申请表

1 5 0 0 0 0 1

SECTION A: BENEFICIARY DETAILS A部分：被保险人详情

To be completed by the beneficiary or his/her agent 由被保险人或其代理人完整填写

1 Full Name 全名	**2** Gender 性别
3 Policy ID 保单号	**4** Policy Holder's Name 投保人姓名
5 Residential Address 常住地址	**6** Full Mailing Address (if different) 邮寄地址（如有不同） Email address电子邮箱
7 Membership ID 会员号	**8** Tel No. 电话号码 Fax No.传真号码
9 Passport Number 护照号码 Or Chinese ID Card Number 或身份证号码 Date of Expiry 有效期限	**10** Are you eligible for full or partial reimbursement for these expenses from another insurer? 你是否有资格获得另一家保险公司的全额或部分费用理赔？ Yes/No 是/否

11 State nature of illness（failure to complete may delay claim settlement） 疾病名称（若不填写可能会延误理赔）

12 If you have answered yes in section 10, please give details below(Full Name, Address of Insurance Company and Policy number)
如果第10条的答案为“是”，请提供以下详细信息（该保险公司的全称、地址和保单号）

SECTION B: PAYMENT DETAILS B部分：付款明细

To be completed by the beneficiary or his/her agent 由被保险人或其代理人完整填写

13 List of expenses for which reimbursement is claimed and amount and currency
请列出理赔报销的费用明细及金额和币种

14 State to whom you wish settlement paid
请提供理赔金的收款人

Treatment 治疗项目	Date 日期	Amount and currency 金额及币种	Payment to 付款至

15 Select payment method
付款方式选择

If claimed amount exceeds RMB 10,000 or other currencies in equivalent, we require a copy of the patient's valid identification(i.e. ID card or passport).
如果理赔金额超过10,000人民币或等值外币，请提供病人的有效身份证件（如：居民身份证或护照）。

Bank Transfer 银行转帐 ☐ Cheque 支票 ☐

16 State reimbursement currency that payment should be made. Claims incurred in China will automatically be paid electronically in RMB
请声明理赔款币种。在中国的保险理赔将以人民币自动电子结算支付

17 If payment is to be sent to your bank account, please complete the following: 如果付款至银行账户，请完整填写以下信息：

Bank Account No.开户行账号 Bank Name开户行

Sort Code 国际代码 Bank Branch Name and Address 银行分行名称和地址

Swift Code* Swift代码* IBAN* IBAN代码*

*by providing this information, payment will be transferred more efficiently by the receiving bank

*提供这些信息有利于受理行更有效地转帐支付

Name on the Account(must be exact) 账户名（**务必准确**）

SECTION C: Anti-fraud Prompt C部分：反保险欺诈提示

Honesty is a fundamental principle under insurance contracts. People involved in insurance-related fraud can be held accountable as follows:
Criminal Penalty: People engaging in insurance-related fraudulent actions can be subject to criminal proceedings that may result in a combination of detention, imprisoment, fines and confiscation of property. This applies equally to those who assess insurance incidents or provide evidence related to an insurance incident and intentionally submit false evidence or documentation to support the fraud of others. Such people may be criminally penalized as accomplices to the fraudulent activity.
Police Sanction: People engaging in insurance-related fraudulent actions that are not deemed as serious as criminal activity may still be subject to police sanctions, including detention for up t0 15 days and a fine of up to RMB5000. These sanctions are equally available to those who assess insurance incidents or provide evidence related to an insurance incident and intentionally submit false evidence or documentation to support the fraud of others.
Civil Liability: Failure to perform the duty of truthful disclosure, either intentionally or due to gross negligence, could result in the insurance company's refusal to pay or reimburse claims.

最大诚信是保险合同基本原则，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，将会受到最高十年以上有期徒刑，并处罚金或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，将会受到15日以下的拘留、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，或者投保人、被保人故意制造保险事故的，保险公司不承担赔偿或给付保险金的责任；以伪造、变造的有关证明、资料或者其他证据，编造虚假的事故原因或者夸大损失程度的，保险公司对其虚报的部分不承担赔偿或给付保险金的责任。

SECTION D: Declaration and Authorization D部分：声明及授权

1.I hereby declare that the above statements and facts are correct and I have read through and understood the Anti-fraud Prompt. If I engage in or commit insurance fraud, the insurance company has the right to share the relevant claims information in the insurance industry information sharing.

2.I declare that all the information I provided for this consultation is true and I also hereby confirm that I have reviewed and signed for all other related information including medical description that doctor recorded. I understand that changing these information may lead to a payment delay, partially denial or Whole denial.

3.I acknowledge and authorize Cigna & CMB Life Insurance Company Limited (hereinafter referred to as "Cigna & CMB") to process the personal information of the policyholder, the insured and the beneficiary (hereinafter collectively referred to as "personal information") for the purpose of concluding and performing insurance contracts, providing products and services, and fulfilling legal obligations. With respect to the personal information of other subjects provided by me, I confirm that I have obtained authorization from these subjects.

4.I agree and authorize Cigna & CMB to inquire and collect my personal information from credit reporting agencies, medical institutions and other third-party cooperative institutions for the purpose of concluding and performing insurance contracts, and providing underwriting, preservation, claim settlement, customer service, etc.

5.I agree and authorize Cigna & CMB to provide the personal information provided by me, or inquired and collected in accordance with the above agreement to the affiliated companies of Cigna & CMB and other third-party cooperative institutions (such as health management companies, medical institutions, reinsurance companies, etc.) necessary for the provision of services.

6.I agree and authorize Cigna & CMB to provide the personal information to the judicial authorities, the People's Bank of China, China Banking and Insurance Regulatory Commission and its dispatched agencies and other regulatory authorities, or third parties designated by former regulatory authorities, insurance industry associations, trade associations and other relevant organizations for the purpose of fulfilling legal obligations.

7.I agree and authorize Cigna & CMB, its affiliated companies and partners who shall be necessarily entrusted to offer me such services as insurance products recommendation, claim settlement and other customer services, including market research and information data analysis, during, before and after the term of insurance contract.

8.I acknowledge and agree that personal information including name, gender, nationality, occupation, address, contact information and ID card information, as well as sensitive personal information such as biometric characteristics, medical health and financial accounts, are required for Cigna & CMB to conclude and perform contracts and provide services. I further agree that Cigna & CMB can process personal information by collection, storage, use, processing, transmission, provision and deletion, and that its privacy policy is applicable.

9.I acknowledge that I have the legal right to access, correct, delete and withdraw my consent for the processing of my personal information in accordance with the law. My exercise of the above rights will not be in violation of the purpose of concluding and performing insurance contracts and obtaining customer services, nor will it be in conflict with Cigna & CMB's performance of legal obligations.

Special Notes:

1.Cigna & CMB attaches great importance to the protection of personal information and will do its best to protect clients' personal information reasonably by means of authority management, encryption management, restricted access, signing of confidentiality agreements with relevant institutions or personnel, etc. If you do not agree with the terms or part of terms of this Authorization Letter, you can call Cigna & CMB's customer service hotline [400-820-7553] to make amendments. Please keep your account, password and other personal information properly. The operation under your account will be regarded as your operation. If you disclose any information that may adversely affect you, you can contact Cigna & CMB immediately.

2.Cigna & CMB also attaches great importance to the protection of minors' information. If the insured is a minor under the age of 14, the guardian shall carefully read the terms of this Authorization Letter before making authorization.

3.For sensitive personal information such as your biometric characteristics, medical health, financial accounts, etc., your special consent is required.

4.Cigna & CMB will provide your personal information to the overseas entities to perform above-mentioned services if your insurance plan involves overseas medical services, emergency treatment, etc., please give your consent specially.

5.Cigna & CMB may revise its privacy policy in due course and publish updates through its official website (www.cignacmb.com) and APP, please check such revisions in time.

1、本人的陈述与事实确实无误，且已阅读并知晓《反保险欺诈提示》，若本人参与或实施保险欺诈行为，保险公司有权将相关理赔信息纳入保险行业共享范围。
2、本人确认本次就诊中所描述的所有信息属实，并已签名确认医生所记载的与本次就诊相关的其它的病历资料也属实。本人了解更改相关病历资料会造成理赔款的支付延误、部分拒赔甚至全部拒赔。
3、本人已知晓并授权招商信诺人寿保险有限公司（以下简称“招商信诺”）为订立、履行保险合同，提供产品和服务，以及为履行法定义务，将处理投保人、被保险人及受益人的个人信息（以下统称“个人信息”）。就本人所提供的其他主体个人信息，本人确认已取得相关主体的授权。
4、本人同意并授权，为订立和履行保险合同，提供核保、保全、理赔、客户服务等目的，招商信诺可向征信机构、医疗机构、以及其他单位、组织等第三方合作机构查询、收集本人的个人信息。
5、本人同意并授权，招商信诺可将本人提供的以及根据上述约定查询、收集的个人信息提供给关联公司,以及其他为提供服务所必须的第三方合作机构（如健康管理公司、医疗机构、再保险公司等）。
6、本人同意并授权，为履行法定义务，招商信诺可将个人信息提供给司法机关、中国人民银行、中国银保监会及其派出机构等监管机构或其指定的第三方、保险行业协会、同业公会等相关机构组织。
7、本人同意并授权，在保险合同期间、或订立前、终止后，招商信诺、关联公司及因服务必须委托的合作伙伴可向本人提供、推荐保险产品、理赔服务、及其他客户服务，如市场调查与信息数据分析等。
8、本人知晓并同意，个人信息包括姓名、性别、国籍、职业、联系地址、联系方式、身份证件信息、以及生物识别、医疗健康、金融账户等敏感个人信息，该等信息是招商信诺为订立、履行合同及提供服务所必需；同意招商信诺对个人信息的处理方式包括收集、存储、使用、加工、传输、提供、删除等；同意适用招商信诺隐私政策。
9、本人知晓，在符合法律规定的情形下，本人对个人信息拥有合法的查阅、更正、删除、撤回同意权。本人行使上述权利不会与为订立、履行保险合同及获得客户服务相违背，也不会与招商信诺履行法定义务相冲突。

特别提示：
1、招商信诺非常重视个人信息保护，并尽最大努力合理保护个人信息，包括采取权限管理、加密管理、限制访问、与相关机构或人员签署保密协议等方式。如您不同意本授权条款或其中部分条款，可致电招商信诺客服热线【400-820-7553】修改授权。请您妥善保管您的账户、密码及其他个人信息。您账户下的操作行为将视为您本人的操作行为。一旦您泄露该信息，如可能会对您有不利影响，您可立即与我们联系。
2、招商信诺重视未成年人的信息保护。如被保险人为不满14周岁的未成年人，请监护人仔细阅读本授权书条款，并予以授权。
3、您的生物识别、医疗健康、金融账户等信息属于敏感个人信息，提请您特别同意。
4、如本保险计划涉及境外医疗服务、紧急救援服务等情形的，招商信诺将为履行上述服务向境外实体提供您必要的个人信息，提请您特别同意。
5、招商信诺可能适时修订隐私政策，并于官网（www.cignacmb.com）、APP公布更新，请您及时查阅。

Signature of Beneficiary (or Parent/Guardian if under 18)
被保险人签字（如未满18周岁，请法定监护人签字）

Date
日期

SECTION E: MEDICAL INFORMATION **E部分：医疗信息**

To be completed by Treafing Physician - PLEASE PRINT **由诊疗医师完整填写—请用正楷书写或打印**

(If your beneficiary is claiming for vision please only complete section 20) (如果被保险人理赔视力项目，仅需完整填写第20项）

18 Please state the date of which the beneficiary first consulted you for this condition 请陈述该被保险人首次诊询该病情的日期

19 Date the symptoms first occured 该病情症状首次出现日期

20 Please give your diagnosis of the illness/injury 请提供该病情 / 受伤情况的诊断结论

21 Please give details of treatment 请提供治疗详情

22 Please print your name and address and authenticate with an official practice stamp
请正楷书写或打印您的姓名和地址，并加盖医院诊断章

Signature of Treatment Physician 诊疗医师签字

Date 日期

Please return your completed original claim form、include original invoices and receipts as well as other relevant claim documents to：
请将完整填写的理赔申请表原件、发票和收据原件及相关理赔材料交至:

Cigna & CMB IPMI Claim Team
3rd Floor, Building 12 of Lujiazui Software Park, No.130, Lane 91, EShan Road, Pudong New Area, Shanghai, 200127

招商信诺人寿保险有限公司个人高端医疗险理赔部
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