永诚财产保险股份有限公司
ALLTRUST INSURANCE COMPANY LIMITED

GBG
Insurance Without Borders™

Alltrust-GBG UniCare Student Insurance Claim Form

永诚-GBG 留美护航学生保险理赔申请表

This claim form is to be used only if your provider did not file claims directly to GBG on your behalf. Return this form ***along with fully itemized bills and diagnosis*** to the address below. Claims Services recommend claims to be submitted within one hundred eighty days (180) after first day of treatment.

仅当您的医疗服务机构未直接以您的名义向 GBG 申请赔理时，您才需要填写此表。将本申请表填妥后，**连同完整的收费清单及诊断证明**寄往如下地址。理赔服务中心建议在治疗结束后起的（180）天内，尽快提交理赔申请。

*GBG China Claim contact information *GBG 中国理赔联系信息：

Shanghai Claims Center: Suite 2104,SCG Datang International Plaza, 868 Yinghua Road, Shanghai 201204, P. R. China

上海理赔中心：上海市浦东新区樱花路 868 号建工大唐国际广场 2104 室 邮编 201204；

Tel 电话: 400-816-9300; Email 电子邮件: aicclaims@gbg.com; Claim Status Inquiry 理赔状态查询: aicclaims@gbg.com

*GBG is a Claims Service Center authorized by Allturst Insurance

*GBG 是永诚保险授权的理赔服务中心

Section 1: Policyholder Information 第一部分：投保人信息			
Name 投保人姓名			
Policy No. 保单号码		**Member No. 会员号**	
Current Resident Address and Country **当前居留国家及居住地址**			
E-Mail 电邮		**Mobile Phone 手机号码**	**Fax 传真**
Is the Policyholder an Insured Member? 投保人是否是被保险人？ □ Yes 是 □ No 否			
Section 2: Applicant Information 第二部分：申请人信息 **Section 2-A:Claimant Information 2-A 区：理赔申请人信息**			
Is this claim for a Primary or Dependent Insured? 本次理赔申请人是主被保险人还是附属被保险人？ □ Primary Insured 主被保险人， □ Dependent Insured 附属被保险人			
Last Name 姓	**First Name 名**	**Gender 性别** □ Male 男 □ Female 女	**Passport/ID 护照/身份证号**
Nationality 国籍国	**Primary Insured's School Name 主被保险人留学学校**	*All full time students must have a letter verifying full-time student status from their school's registrar office at the beginning of each school year. 所有全职在校生在每学期开学时，必须具有从学校注册管理处开据的全职学生身份证明书。*	
Section 2-B: Contact Information 2-B 区：联系人信息			
Last Name 姓	**First Name 名**	**Gender 性别** □ Male 男 □ Female 女	**Passport/ID 护照/身份证号**
Residential Address 居住地址		**City 城市**	**Country 国家** / **Zip Code 邮编**
Mobile Phone 手机号码		**Email 电邮**	
Section 2-C: Contact Information 2-C 区：紧急联系人信息			
Last Name 姓	**First Name 名**	**Mobile Phone 手机号码**	

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Section 3: Claim Information 第三部分：理赔信息

Was the claim for: 该理赔为：

□ Health 医疗相关费用 — If choose this, please complete Section 3-A. 如选择此项，请填写 3-A 区。

□ Non-Health 非医疗相关费用 — If choose this, please complete Section 3-B. 如选择此项，请填写 3-B 区。

Section 3-A: Health Claim 3-A 区：医疗相关理赔

Medical records are necessary for claim reviewing. If there are no medical records, please ask doctor to fill out blank space of section 3, put down his signature and have it stamped by the hospital. GBG will deem the information as valid medical information.（If you cannot provide required records, your claim application will be delayed or rejected）

医学病历是理赔审核必须的材料。提交理赔申请时，若无法提供与就诊日期对应的详细病历，烦请医生协助填写第三部分，并签名及医院盖章后，可充当有效的医学信息。（如若无法提供所需资料，您的理赔将可能会有所延迟或者被拒绝）

Nature of illness/injury: 患病/受伤情况：

Date illness/injury occurred: **患病/受伤日期**	**Time illness/injury occurred:** **患病/受伤时间：**
Where the illness/injury occurred: 患病/受伤地点：	**Please provide a detailed description of how the injury occurred:** **请详细描述该患病/受伤是如何发生的：**

Name and address of doctor(s) and/or hospital(s) from which the treatment was received:

请注明接收治疗的医生(们) 以及/或医院的名字和地址：

If treatment was given in hospital as an inpatient please confirm the admission date and discharge date:

若该治疗需要住院，请注明住院日期与出院日期

Was the Emergency Assistance Company contacted: 是否联系过紧急医疗救援公司？ □ Yes 是 □ No 否

Was the Insured Person pregnant: 被保险人是否怀孕？ □ Yes 是 □ No 否 **If yes, how many weeks?如果是，怀孕几周？**

Is this claim for Maternity treatment? **此次申请理赔是否属于生育治疗？** □ Yes 是 □ No 否	**Name of Treating OB/GYN** **妇产科医生名字**	**Date of Last Menstrual Period** **上次月经期**	**Estimated Delivery Date** **预产期/分娩日期**

The following treatments and or prescribed drugs were provided to me and the charges for each are listed below. (ATTACH ORIGINAL COPY OF RECEIPTS in order to receive payment) 以下分列出所有接受的医疗服务和(或)处方药物及其费用 (依照保险理赔条款,需附上所有费用收据及帐单原件)。

Date of Service 治疗服务日期			
MM/DD/ YY 月/日/年	Description of each service and/or prescribed drug 描述每项医疗服务和或处方药物	Cost 费用	Currency 货币
	Total Amount Paid by Patient 患者支出金额合计		
	Total balance still due to provider 未付医疗机构的差额合计		

Has diagnosis and/or treatment for same condition or related condition been given previously? If so, state dates, results, kind of treatment, prescribed drugs and name of doctor or facility: 以前是否有过相同或相关的诊断或治疗？如果有，请注明日期、结果、治疗措施、处方药物、以及医生姓名或医疗机构名称

□ Yes 是 □ No 否

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If treated in your Home Country for this condition/symptoms or a similar condition, indicate the treatment recommended/medication prescribed and date first treated
在国籍国是否有过相同或相关的诊断或治疗？如果有，请注明日期、结果、治疗措施、处方药物、以及医生姓名或医疗机构名称

Section 3-B: Accident Death or Dismemberment Claim 3-B 区： 意外死亡或伤残理赔

Location of Accident Occurrance: **事故发生地点：**	Date/Time of Accident Occurance: **事故发生日期/时间：**

Please detail the nature of how the accidental death or dismemberment occurred:**请描述意外死亡或伤残的发生过程：**

Was journey organized by school 是否学校组织 □Yes 是 □ No 否	Dates of journey: **旅行日期：** From： To: (DD/MM/YYYY, i.e. 01/08/2017)

Is the Injury Related to: **受伤是否为以下原因造成？**	If due to a motor vehicle Accident, please list names of all drivers and Companies Insuring all drivers and/or vehicles **若是机动车意外事故导致的伤害，请填写所有相关驾驶员与车辆及驾驶员的保险公司信息**
□ School Sponsored Trip or Activity 学校组织旅行或活动 □ During Practice or Play of an Intercollegiate Sport (Please provide copy of School Injury Report) 校际运动比赛或操练（请提供学校校意外伤害报告） □ Sport or Activity Outside of School 学校以外运动或活动 □ Motor Vehicle Accident (Please provide Police Report) 机动车意外事故（请提供警方报告） □ Work-Related Injury 工伤	

In the event of a fatality, a Death Certificate issued by a licensed authority must be obtained, with the original copy being submitted to GBG.
若意外死亡，必须将由授权机关发布的死亡证明原件提交给 GBG。

Beneficiary Name (Last, First): **理赔受益人姓名（姓，名）：**

Relationship to the Late Insured:**与已故被保险人关系：**

Address: **联系地址：**

City:**城市：**	Country:**国家：**
Postal Code:**邮编：**	Email:**邮箱：**

Section 3-C: Non-Health Claim 3-C 区： 非医疗相关理赔

Was journey organized by school 是否学校组织 □Yes是 □ No否	Dates of journey: **旅行日期** ： From： To: (DD/MM/YYYY, i.e. 01/08/2017)
Date of baggage loss: **行李遗失日期：**	Time: **时间：**

Please provide a detailed description of how the loss occurred, including the location:
请详细描述行李如何遗失的，包括遗失地点：

Please confirm when the loss was reported and to which authority (e.g., police/airline/tour operator/hotel, etc.), including complete address and reference:
请确认何时并且向哪个机构报告行李遗失的（例如：警局/航空公司/旅行社/酒店等）包括完整的地址及参考依据：

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If the loss relates to travellers cheques, cheques, cash, credit, bankers/charge card, provide date that the issuer was notified:

如果遗失行李中包括旅行支票、支票、现金、信用卡、银行卡，请提供告知其发行方的日期：

ITEM DETAILS 物品详情

Full description of item 1: 物品1详细介绍：

Where purchased: 何地购买：		Date purchased (MM/DD/YY): 购买日期：
Price paid: 支付金额：	Cost now:目前价值：	Amount claimed: 理赔金额：

Full description of item 2: 物品2详细介绍：

Where purchased: 何地购买：		Date purchased : 购买日期：
Price paid:支付金额：	Cost now:目前价值：	Amount claimed:理赔金额：

ADDITIONAL DOCUMENTS REQUIRED 额外材料要求

- In the event of a personal baggage loss, all incidents MUST be reported to the local police within 24 hours. An incident number and loss report must be obtained and submitted to International Claims Services.
- 当发生个人行李遗失，所有事件必须在24小时内报告当地警察，且必须获得一个事件编号和遗失报告，并提交给国际理赔服务中心。
- If the loss occurred at the airport or on the aircraft, the incident MUST be reported to the airline within 24 hours through an Incident Report. We require the Incident Report to be sent with this claim form.
- 如果遗失发生在机场或飞机上，事件必须在24小时内通过事件报告向航空公司报告。我们要求提交理赔申请表时附上该份事故报告。
- Provide proof of the original purchase/ownership, i.e., receipts, bank/credit card statements, photographs, packaging, instructions manuals, valuations.
- 请提供原始购买/所有权证明，即收据、银行/信用卡帐单、照片、包装、说明手册、估价值。
- Please note that we may make a deduction on the claim if proof of purchase is not provided and/or if wear-and-tear is applicable.
- 请注意如果没有提供购买证明，我们可能会考虑到磨损情况在理赔中扣除部分价值。

LOSS OF PASSPORT 护照丢失

Please confirm where the passport was lost:请确认护照在何地丢失：

Please provide details of the expenses incurred to replace the passport, including receipts: 请详细提供更换护照的费用，包括发票：

ATM SAFE ATM安全

Date of the loss occurred: ATM失窃发生日期：	Time of the loss occurred: ATM失窃发生时间：
Location of the loss occurred: ATM失窃发生地点：	Amount of the loss :失窃金额：

Section 4: Other Insurance Information 第四部分：其他保险信息

Does the Insured Member have other Insurance? 被保险人是否有其他保险？ □ Yes 是 □ No 否	Is the Insurance a Health/Travel Insurance Plan? 其他保险是否是健康/旅游保险？ □ Yes 是 □ No 否

Other Insurance Company Name and Address 其他保险公司名称和地址	Policyholder Name for Other Insurance 其他保单投保人	Policy Number and Effective Date of Other Insurance 其他保险保单号和生效日期

Is the Claimant Eligible for Medicare? 理赔申请人是否持有美国联邦医疗健保福利？ □ Yes, Part A 是，A部分 □ Yes, Part C 是，C部分 □ Yes, Part B 是，B部分 □ Yes, Part D 是，D部分 □ No 否	If yes, Medicare ID Number 若是，请注明联邦医疗健保福利会员号

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Section 5: Payment Information 第五部分：付款信息

Member will only be reimbursed if acceptable proof of payment is submitted with claim. 持保人提交理赔时必须附上相关合格的付款证明，方可获得赔偿。

- **For member: Acceptable proof of payment includes receipts from the Provider(s) and itemized billings noted for hospital or physicians.**
  对于持保人：合格的付款证明包括医疗供应商提供的收据及医院或医生注明的账单明细
- **For US Hospital Charges: All hospital submissions must be itemized on a UB-92 form with proof of payment (box 54) completed.**
  对于美国医院费用：所有医院必须提交列入 UB-92 表内的分项明细及已完成的付款证明（box 54）
- **For US Physician charges: All physician submissions must be itemized on a HFCA/CMS-1500 form with proof of payment (box 29) completed**
  对于美国医生费用：所有医生必须提交列入 HFCA/CMS-1500 表内的分项明细及已完成的付款证明（box 29）

Make Payment To 收款人

□ Member 被保险人　　□ Provider 医疗服务机构

Send check and Explanation of Benefits (EOB) to:
将支票和理赔通知单（EOB）寄至：

□ Mail to Member Address on Section 1 寄至列于第一部分的通讯地址

□ Mail to Other Mailing Address 寄至列于其他地址

□ Send by Wire Transfer 电汇付款

If you Selected Other Mailing Address, Please Specify Address
若选择邮寄至其他地址，请填写地址

If you selected Wire Transfer, please provide below information:
若选择电汇付款，请提供以下银行信息

Name of Bank 开户行支行名称：	
Name on Account 开户人姓名：	
Account #/IBAN 账号：	
Routing Number (ABA) for Electronic Transfer, and/or SWIFT code for Wire Transfers 银行转帐代码 (Routing/ABA Number) 或银行汇款代码 (SWIFT Code)：	
Bank Address 银行开户行地址：	

Section 6: Certification and Signature 第六部分：证明及签名

I authorize any health care provider, medically related facility, health care plan, insurance company, and the Medical Information Bureau and their representatives to give Alltrust Insurance Company, GBG or their agent's any and all information, including complete medical history records and mental health and substance abuse records, for consideration of this claim and all future claims. A photocopy of this form shall be just as valid as the original. I hereby certify that the above statements are complete and correct to the best of my knowledge and that I am claiming benefits only for the charges incurred by the above named member.

我授权任何医疗服务供应商、医疗相关机构、药店、保险公司、和医疗信息局及他们的代表向永诚财产保险股份有限公司、GBG 或他们的代理人提供任何及所有信息，包括完整的医疗诊断历史纪录和精神疾病及滥用药物记录，以便该次理赔和未来所有理赔参考。该申请表的复印件应与原件同样具有效力。

我特此证明，本申请表中的内容为本人尽所能提供，且内容是完整和准确的。同时，我申请的福利理赔仅为上述指名持保人产生的费用。

Claimant Signature **理赔申请人亲笔签名**	**Date** **日期**
Parent/Guardian Signature if Insured Member is a minor **若被保险人是未成年人，父母或监护人亲笔签名**	**Date** **日期**

FRAUD WARNING: Any person, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, who submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud. claim form.

欺诈声明:任何故意损害，欺骗或欺诈保险公司，提供含有虚假信息、不完整信息或误导信息的理赔申请都需要承担法律责任。

Please submit copies of your current Passport and Student visa along with this Claim Form

请您将护照以及留学签证复印件与本理赔申请表一起递交