Group Insurance Dental Claim Form 团险牙科索赔申请表

Section A General Information A. 基本信息

Insured Information 被保险人信息

Primary Insured Information 主被保险人信息

Name 姓名		Employer Name 投保单位名称	
ID/Passport# 证件号码		Employee# 员工号	
Telephone# 电话号码		Email 电子邮箱	

*If this is the claim for primary insured, dependent information can be skipped.
*若理赔仅涉及主被保险人，则无需填写附属被保险人信息。

Dependent Information 附属被保险人信息

Name 姓名		Relationship with Primary Insured 与被保险人关系	☐Spouse 配偶 ☐Child 子女	☐Parent 父母 ☐Guardian 监护人
ID/Passport# 证件号码		Telephone# 电话号码		

*If claim amount exceeds RMB10,000 or other currencies in equivalent, copy of beneficiary's identification (i.e. ID or passport...) is required.
*若索赔金额超过人民币10,000元或等值外币，请提供被保险人的有效身份证件（如身份证、护照等）。

Payment Information 给付信息

Expenses for Which Reimbursement is Claimed 申请报销费用明细及金额

Date 日期	Description of Injury, Illness or Treatments 受伤、疾病或治疗描述	Currency 货币种类	Amount 金额

☐ I, the beneficiary, authorize Generali China Life Insurance Company to transfer reimbursement into the bank account designated. 本人授权中意人寿保险公司（以下称"贵公司"）将赔付款项划入本人已在贵公司指定的银行账户。

Claim File Management 索赔单据管理

1. In the event that original medical receipts are required for reimbursement from other insurers, we suggest you may submit claim to such insurers first; 若本次索赔的医疗费用收据原件需提交给其他保险机构进行赔付, 请您先行向其它保险机构进行索赔;
2. Generali China accepts original copy of ***Explanation of Benefits*** from other insurers along with photocopy of relevant medical receipts and medical proofs to process claim; 中意人寿接受并可受理持其它保险机构出具的理赔明细说明书（理赔分割单）原件及相应的医疗费用收据和医疗证明复印件的索赔申请;
3. In the event that you may prefer submit claim to Generali China prior to other insurers, original medical receipts won't be returned however ***Explanation of Benefits*** is available as the substitute of the original medical receipts; 若您选择先行向中意人寿索赔则医疗费用收据原件不予退还，但可出具理赔明细说明书（理赔分割单）以作为医疗费用收据原件替代文件以便被保险人后续向其他保险机构进行索赔;
4. In case of incident 3, please clarify if ***Explanation of Benefits*** is required; 若属上述第3项情况, 请告知是否需要理赔明细说明书（理赔分割单）: ☐Yes 是 ☐No 否

Declaration and Authorization 声明及授权

I hereby declare that the above information is provided by myself and no material has been withheld and information given herein is true. I authorize that any doctors, hospitals, clinics, insurance companies, police institutes and public or private organizations that keep any medical history or records or knowledge of me who I have attended or may hereafter attend to disclose such information to Generali China Life Insurance Co. Ltd. for the purpose of assessing and processing insurance application, claims or subsequent services. I hereby agree that any personal information collected by the Company is provided and may be held, used, disclosed and transferred by the Company for the purpose of insurance, reinsurance, data processing and statistics. I understand that any transfer of the claim payment from insurer through designated bank shall be deemed as the payment has been delivered.
本人经过仔细审阅后确认上述所填内容、答案及与之有关的资料均为本人亲自提供且完整并确实无误，无隐瞒或遗漏。本人授权任何医生、医院、诊所、保险公司、公安机关、任何公立或私立的组织单位，在任何时候均可以将有关被保险人的资料、报告或文件交给中意人寿保险有限公司及其代表，此授权书的副本与正本具有同样效力。本人同意中意人寿保险有限公司将有关被保险人的资料用于保险、再保险、数据处理及统计事宜。本人清楚明白中意人寿保险有限公司的赔偿款项一经通过银行成功转账至本人所指定的账户，将视为本人已收到该笔赔偿款项。

Signature of Beneficiary or Guardian 被保险人或其法定监护人签名	Date dd/mm/yy 日期