Smartcare Exclusive Group Plan

Medical Claim Form

Please complete this form as truthfully and accurately and return with the supporting documents within 30 days after the occurrence of the claimed condition to:
Shanghai CHC Health Technology Co.,Ltd.
7F, Jintian Business Building, 1295 Lujiabang Road, Huangpu Area,
Shanghai, P.R.C.
Service hotline: 400 690 0050 (or +86 400 690 0050 for overseas call)

WECHAT
OFFICIAL ACCOUNT
微信公众号

Further information/documents may be requested depending on the nature and extent of the claim. Separate forms must be used for different claimants.

PART 1 - THE INSURED PERSON/CLAIMANT			
POLICY NUMBER:	**NAME:**	**SEX:**	**AGE:**
OCCUPATION:	**IDENTITY CARD NUMBER:**		
CONTACT NUMBER:	**EMAIL:**		
RESIDENTIAL ADDRESS:	**POSTAL CODE:**		
If claimant is an infant, please specify: **NAME OF GUARDIAN:**	**RELATION TO CLAIMANT:**		

PART 2 - ACCIDENT CLAIM (Please fill in this part for accident)		
DATE OF ACCIDENT:	**TIME** (AM/PM) **:**	**EXACT PLACE OF ACCIDENT:**
DESCRIBE IN DETAIL HOW THE ACCIDENT HAPPENED:		
PART(S) OF BODY AFFECTED:	**NATURE OF INJURY:**	
POLICE REPORTS, IF ANY: ☐ Yes (Please refer the cognizance)	☐ No	

DISEASE CLAIM (Please fill in this part for disease claim)	
SYMPTOMS AND DIAGNOSIS:	
SINCE WHEN THE SYMPTOM COMPLAINED OF HAS EXISTED:	**NAME OF CLINIC/HOSPITAL OF FIRST CONSULTATION:**
FIRST CONSULTATION (DD/MM/YYYY)**:**	**NAME OF CLINIC/HOSPITAL:**
NAME OF ATTENDING PHYSICIAN:	**DIAGNOSIS FOR DISEASE:**

HOSPITALISATION CLAIM(Please fill in this part for hospitalisation claim)	
NAME OF HOSPITAL:	**NAME OF ATTENDING PHYSICIAN:**
DATE ADMITTED (DD/MM/YYYY)**:**	**DATE DISCHARGE** (DD/MM/YYYY)**:**
DIAGNOSIS:	

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PART 3 - OTHER APPLICABLE INSURANCE	
Has the claim been made against other insurance companies? If so, please state:	
NAME OF INSURER:	**POLICY NUMBER:**
CLAIMED ITEM:	**CLAIMED/SETTLED AMOUNT:**

PART 4 - BANK DETAILS		
ACCOUNT NAME:	**BANK:**	**ACCOUNT NUMBER:**

PART 5 - CLAIMED ITEM AMOUNT & SUPPORTING DOCUMENTS		
5.1 HOSPITALISATION BENEFIT		
CLAIMED ITEM:	**SUPPORTING DOCUMENTS REQUIRED**	**CLAIMED AMOUNT:**
Daily hospital room and board	1. Original Medical Record or Discharge Note issued by in-patient, outpatient or emergency unit; 2. Original Medical Expenses Receipts issued by Hospital; 3. Original Medical Examination Report; 4. Original In-hospital Services Bills.	
Public hospital allowance		
ICU		
Surgical fee		
Prescription drugs		
X-rays, pathology, diagnostic tests and procedures		
Other hospitalisation expense		
Private nursing		
Company (parents/children) Accommodations		
Pre & post hospitalisation treatment		
Psychiatric treatment		
Organ transplant		
5.2 ARTIFICIAL PROSTHESIS		
Artificial prosthesis	1. Document by the shoulder, am, hand, leg, foot and eye	
5.3 OUTPATIENT KIDNEY DIALYSIS/ CANCER TREATMENT		
5.4 EMERGENCY DENTAL		
5.5 EMERGENCY EVACUATION AND REPATRIATION		
5.6 REPATRIATION 0F MORAL REMAINS		
5.7 OUTPATIENT (OPTIONAL)		
5.8 DENTAL (OPTIONAL)		
ALL CLAIMS	1. Copy of claimant's identity card with signature (if claimant is an infant, copy of the payee's identity card with signature is required); 2. Copy of insurance policy/certificate; 3. Copy of claimant's bank book; 4. Other documents as reasonably required by the Company in relation to this claim.	

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PART 6 - DECLARATION AND AUTHORIZATION BY THE POLICYHOLDER

I hereby declare and authorize:

6.1 That I authorize the medical practitioner, Hospital/Clinic or any other medical institution to give the information and/or medical record, according to the diagnosis and/or medication treatment which is/has been given to me or my family member who being as the insured.

6.2 That I authorize AXA Tianping Property & Casualty Insurance Co., LTD. and its designated third party administrators to gather further information/medical records from the Hospital and or other parties related to the diagnosis and or health services provided to me or my family member which may be required to process the claim in accordance with existing policy and term conditions.

6.3 That all information on this hospital admission/pre-authorization claim form (In-patient) is written truthfully and I hereby agree that this Letter of Authority to be used promptly.

6.4 That copy of this Declaration is as valid and has power in accordance with the original document.

6.5 That the approval (where applicable) of this claim does not discharge my obligations to fulfill the terms and conditions under the policy which I and/or family member is/are insured, and also, AXA Tianping Property & Casualty Insurance Co., LTD. is not obliged to pay the ongoing costs of continuing, or similar, treatment, even where AXA Tianping Property & Casualty Insurance Co., LTD. has previously paid for this type of, or similar treatment, if it is subsequently noted that this claim is not an eligible treatment.

6.6 I authorize my Financial Advisor/Broker/Agent to discuss medical conditions as necessary with my insurer or its authorized agent on my behalf.

☐ Please tick the box if you do not authorize your financial Advisor/Broker/Agent to discuss medical conditions with the insurer or its authorized agent on your behalf.

6.7 I consent to AXA Tianping P&C Insurance Co., Ltd. (Hereinafter referred to as AXA TP) providing my personal information to overseas recipients within the following scope.

Name of overseas recipient	Contact information	Purpose of processing	Method of processing	Category of personal information	The methods and procedures for exercising your rights to overseas recipients
AXA Life and Health Reinsurance Solutions PTE. LTD.	Enquiries.ALHRS @axa.com	For the case beyond the claim authority of AXA TP, the detailed data of the claims of the case shall be provided to the designated overseas management organization of AXA (the overseas recipients listed in this form) for application and approval.	Data approval	The personal information contained in the "Section 6 - Required Claim Documents" of this claim application form.	You can contact overseas recipients through the provided contact information in this form.
AXA Global Healthcare (UK) Limited	+44 (0)1892 503 856				

SIGNATURE 0F CLAIMANT:	**SIGNATURE OF GUARDIAN (IF CLAIMANT IS UNDER THE AGE 0F 18):**

DATE (DD/MM/YYYY)**:**

- INTENTIONALLY LEFT BLANK -

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