



太平人寿
TAI PING LIFE



ERV China
欧乐旅行援助

TRAVEL INSURANCE CLAIMS FORM

旅游保险索赔单

Policy No.

保单号

ERV China case No.

欧乐旅行援助案例号

Before filling in this form, please note that the information you provide will form the basis of our processing of your claim. If there are special circumstances that are not adequately covered by the various sections of this form, please let us have the details on a separate sheet of paper together with this form.

在填写此表前，请注意您提供的信息将构成我们履行理赔的根据。如果此表中所列各项未能涵盖一些特殊情况，请随此表附上单独写有详情的文件。

Claim under policy section(s)		In-patient 住院医疗	<input type="checkbox"/>	Out-patient 门诊医疗	<input type="checkbox"/>	Dental treatment 牙科医疗	<input type="checkbox"/>
申请事项		Handling of mortal remains 遗体处理	<input type="checkbox"/>	Travel Curtailment/ Delay 旅行缩短/延迟	<input type="checkbox"/>	Loss of travel documents 旅行证件遗失	<input type="checkbox"/>
Insured's Personal Information		Company 单位		Position/title 职务			
被保险人个人信息		Name (characters and pinyin) 姓名 (汉字和拼音)		Personal ID No. 身份证号码			
		Private address 家庭住址			Tel. office 单位电话		
		Postal code 邮编		E-mail address 邮箱		Tel. private 个人电话	
Applicant's Personal Information		Company 单位		Position/title 职务			
申请人个人信息		Name (characters and pinyin) 姓名 (汉字和拼音)		Personal ID No. 身份证号码			
		Relation to Insured 与被保险人的关系					
		Private address 家庭住址			Tel. office 单位电话		
		Postal code 邮编		E-mail address 邮箱		Tel. private 个人电话	
Detail of Journey		Purpose of journey 旅行目的		Date of departure 出发日期		Date of return 回程日期	
旅行细节		Tour operator/company (if any) 旅行组织者/公司 (如有)		Destination 目的地			
What happened?		When did the injury/illness occur? (date and time) 事故 (伤/病) 发生时间? (日期/时间)		Where did the injury/illness occur? (place) 事故 (伤/病) 发生地点?			
事故经过		When was the injury/illness reported to the hotline? (date and time) 事故 (伤/病) 何时通知救援热线? (日期/时间)					
		Description of what happened – if relevant please use a separate piece of paper or sketch. 事故经过描述 – 如有相关需要您可使用另外的纸张					



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What happened? Continued... 事故经过				
For accidents or assaults 意外事故或遭攻击	Were there any witnesses? If yes, please state name, address and contact details 有无目击者? 如有, 请说明其姓名, 地址和联系方式			
	Yes <input type="checkbox"/> No <input type="checkbox"/> 有 <input type="checkbox"/> 无 <input type="checkbox"/>			
	Has a police report been compiled? If not, why not? 有无警方报告? 如没有, 为什么?			
	Yes <input type="checkbox"/> No <input type="checkbox"/> 有 <input type="checkbox"/> 无 <input type="checkbox"/>			
If the insured has passed away 如被保险人身故	Has the cause of death been determined? 是否已检验死因? Yes (please attach the death report) <input type="checkbox"/> No <input type="checkbox"/> 是 (请附报告) 否			
Details of treatment 治疗详情	Dates on which you consulted or were seen by a physician 看病日期		Period of hospitalisation 住院时期	
			From 从	Until 至
	Diagnosis/Description of illness 诊断/病情描述			
	Have you previously been treated for the same illness? 是否接受过与此相同病情的治疗?			
	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please state the date on which you last received treatment 有 <input type="checkbox"/> 无 <input type="checkbox"/> 如有, 请说明最后一次接受治疗的日期			
	Were you repatriated? 您是否被转运回国?			
Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, when? 有 <input type="checkbox"/> 无 <input type="checkbox"/> 如是, 在何时?				
Has the incident been reported to the Taiping hotline? 事故是否通知了太平救援热线?				
Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what is the case number? 有 <input type="checkbox"/> 无 <input type="checkbox"/> 如有, 案例号是什么?				
Medical history 病史	Name of hospital last visited in China 在中国最后一次看病的医院名称		Name of treating doctor 主治医生姓名	
	Address (including postal code/city and telephone No.) 地址 (包括邮编/城市名/电话号码)		Date of hospital visit 看病日期	
	Names and addresses of hospitals allowed by your public health insurance 社保医院名称及电话			
1.				
2.				
Compensation claimed (please attach original documentation)	Expenses incurred on the account of the illness/injury?与伤/病相关的费用		Foreign currency 外币	RMB 人民币
	Is the compensation to be paid directly to creditors outside China? Enter x for yes 赔偿是否直接支付给中国境外的债权人? 如是, 请划 X			



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赔偿申请 (请附上原始文件)	Physicians fees 医生费用	Number of treatments 治疗次数			<input type="checkbox"/>
	Medicine prescribed by a physician 医生开具的药品				<input type="checkbox"/>
	Transport expenses 运送费用				<input type="checkbox"/>
	Hospitalisation fees 住院费用	Number of days 住院天数			<input type="checkbox"/>
	Extra hotel expenses 额外的酒店费用	Number of days 天数			<input type="checkbox"/>
	Other expenses 其他费用	Please specify 请详细说明			<input type="checkbox"/>
Has any amount been paid out in connection with the above claim? 是否被支付过与以上索赔相关的费用?					
Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, RMB _____ paid out on the date _____ by _____ 支付。 有 <input type="checkbox"/> 无 <input type="checkbox"/> 如有, 人民币 _____ 元, 支付日期 _____, 由 _____ 支付。					
Other insurance 其他保险	Company _____ Policy No. _____	Has the claim been reported to this company? Yes <input type="checkbox"/> No <input type="checkbox"/>			
	保险公司 _____ 保单号 _____	是否在此公司申请过理赔? 有 <input type="checkbox"/> 无 <input type="checkbox"/>			
Method of payment 付款方式	Which bank account do you want the claim balance transferred to? 您希望理赔金转账至哪家银行?				
	Bank name and address 银行名称及地址	Name of account holder 户名	Bank account No. 账号		
Signature etc. 签名	<p>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.</p> <p>The reports can be procured from the health care sector, hospitals and healthcare institutions, public authorities, insurance companies and pension funds.</p> <p>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.</p> <p>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.</p> <p>I declare that the above information is truthful and complete and has been entered in good faith.</p> <p>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。</p> <p>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。</p> <p>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。</p> <p>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。</p> <p>本人声明, 上述信息真实、完整, 且以诚信原则提供。</p>				
	Applicant's signature 申请人签名 _____	Date 日期 _____			