意外健康险保险理赔申请表
Accident & Health Insurance Claim Form

索赔申请人应正确详细填写此申请表，并将附件所列索赔所需的文件于索偿事由发生 30 天内交回保单签发机构
Please complete this form accurately and return with the supporting documents within 30 days after the occurrence of the claimed condition to the insurance company.
视索赔性质及金额，保险公司有权要求进一步资料。 每份申请表仅限一位索赔申请人填写。
Further documents may be requested depending on the nature and extent of the claim. Separate forms must be used for different claimants.

被保险人/索赔申请人资料 Insured / claimant				
本保单属于 The policy is: ☐年度保单 Annual policy ☐ 团体保单 Group Policy ☐其他 Other			保险期间 Coverage period: 由 From 到 To	
保险单号码 Policy Number			(旅行险类)行程日期 / 保险期间(Travel Insurance) Trip period / coverage period 由 From 至 To	
姓名 Name	性别 Sex	年龄 Age	职业 Occupation	身份证号码 ID Number
通讯地址 Address	邮政编码 Postal Code	联系电话 Phone	电邮地址 Email	
索赔申请人如为未成年人，请注明 (If the claimant is a child, please specify)				
监护人姓名(Name of Guardian):		与索赔申请人关系(Relation to claimant):		

申请赔偿事由 Claimed Item		
发生地点 Place of occurrence	事发日期 Date of occurrence	时间 Time 上午/下午 (AM/PM)
请详细描述申请赔偿事由（经过）Describe in detail how the accident happened:		
证人姓名 Name of witness	地址 Address of witness	联系电话 Phone of witness
如果此次损失可向其他保险公司索赔，请说明 If the claim has been made against other insurance companies, please state		
保险公司 Insurance company:	保险单号码 Policy number:	
索赔项目 Claimed item:	索偿/已赔付金额 ¥ Claimed/Settled amount	

银行账户资料 Bank Details 赔款将通过银行转账支付。任何索赔申请，均须填写此部分 Settlement will be credited to your account by bank transfer, please provide the following details:		
户名 Account Name：	开户银行 Bank：	账号 Account Number：

声明，授权及签署 Declaration, authorization and signature

本索赔申请表签署人（等）谨此声明， 就我（等）所知所信， 以上陈述绝无虚假和隐瞒。我（等）明白保险合同的各项规定，不因本表之提供或史带财产保险股份有限公司（"贵公司"）代表所为之准备或贵公司对索赔证明之接受或保留，而受任何影响。The undersigned declare that the above statements are fully and truly made. I understand that the furnishing of this form to me, or its preparation by any representative of the insurance company, shall not constitute its waiver of any of the conditions of the policy.

本索赔申请表签署人（等）授权任何知悉或拥有本人/被保险人之健康状况及病历或任何治疗或咨询记录、意外事故细节及曾为或将为本人/被保险人之诊治之医生，医院，诊所，公安部门，保险公司或任何机构、组织或人士，向贵公司或其代理人透露有关资料， 不得撤回，即使本人/被保险人死亡或丧失能力，此授权书仍然具有法律效力，而本人/被保险人之继承人及转让人也会受本授权书约束。本授权之复印件与原件同属有效。

The undersigned authorize any physician, medical practitioner, hospital, clinic, police authority, insurance company or any other organization and institution that has any record or knowledge of me/the insured's health and medical history or any treatment, advice or accident details and that has been or may hereafter be consulted to disclose to the insurance company. This authorization shall bind me/the insured's successors and assigns and remain valid notwithstanding me/the insured's death or incapacity in so far as legally possible. A photocopy of this authorization shall be considered as effective and valid as the original.

索赔申请人签署 Signature of claimant： 日期 Date：	监护人签署 （若索赔申请人为未成年人）Signature of guardian(if claimant is a child)： 日期 Date：

本索赔申请表以中文表述为准 Should there be any discrepancies between Chinese and English version, the Chinese version shall prevail.