Group Insurance Claim Form

Policy Number: _____ Policyholder: _____

Part One: Basic information

Employee's name: Employee Number:

ID Number: □□□□□□□□□□□□□□□□□□ Contact Number:1 _____ 2 _____

Current Occupation: Job Description: Working Place:

Claimant's name : _____

Relationship with insured: ☐employee ☐spouse ☐parents/children ☐guardian (Please specify)

ID Number: □□□□□□□□□□□□□□□□□□ Employee Number:

Part Two: Claim Item / Amount

☐accidental medical reimbursement: ¥ ☐ Inpatient expenses: ¥

☐outpatient expenses: ¥ ☐maternity: ¥ ☐Daily inpatient reimbursement: day ¥

☐Daily ICU Reimbursement: day ¥ ☐outpatient treatment expenses of cancer and dialysis: ¥

☐accidental disability: ¥ ☐disability reimbursement: ¥

☐accidental burns reimbursement: ¥ ☐dread disease reimbursement: ¥

☐public pooling: ¥ ☐specified accidental dismemberment reimbursement: ¥

☐death reimbursement: ¥ ☐others: ¥

☐ I, the claimant, authorize Generali China Life Insurance Company (hereinafter referred as to the Company) to transfer relevant reimbursement to the designated bank account

Note: If you never designate a bank account in our company, please provide the "Letter of Authorization of Bank Automatic Transfer" and the copy of bankbook as well as bank card

Part Three: For accidents

Date of accident occurred: Year Month Day Hospital:

The beginning date of treatment: Year Month Day

The end of treatment: Year Month Day The process and result of accident::

Part Four: For disease

Diagnosis: _____ Duration of symptom: _____ Day

1, Date of first diagnosis: _____ 2, Date of further diagnosis: _____

Date of admission: Year Month Day

Hospital: Date of discharge from hospital: Year Month Day

Part five: For death

Date of death: Year Month Day Time Hospital: _____

Cause of death: _____

The process of accident:

Part sixth: Note

In the event that original receipts of medical expenses are required to submit to other organization to apply for claim reimbursement, please claim from that organization first and keep copy of relevant medical receipts; after obtaining the reimbursement payment explanatory statement from that organization, you can submit the original copy of this statement together with copy of relevant medical receipts to Generali China for claim reimbursement. In the event that you choose to claim from Generali China first, please keep copy of medical receipts and we will provide claim settlement explanatory statement after assessment of your claim.

Declaration and Authorization

1. I hereby declare that all above information is provided by myself;
2. I hereby declare that nothing material has been withheld and all the information given herein is true;
3. I authorized that any doctors, hospitals, clinics, insurance companies, police institutes and any public or private organizations reserve the right to submit relevant information, report or document of insured to the Company and its representative at any time. The copy of this authorization is valid as the original one.

4. I hereby agree that any personal information can be used by the Company for the purpose of insurance, reinsurance, data processing and statistics etc

5. I understand that any successful transfer of claim reimbursement from the Company to the designated bank shall be deemed as the payment has been delivered.

Please double check all above information before signing and keep the pattern of signature consistent with the one in policy

Policyholder Chop	**Signature of claimant**	**Date**	**Contact Number of Claimant**

(If the claimant is a minor, please ask for his/her guardian to sign)

Following part is reserved by Policyholder

Employee's name: **Number of invoices:**

Insured's name: **Claim amount:**

Insurance Company: **Date:**

Claim document reference table

Application item	Documents supposed to provide	Application item	Documents supposed to provide
Inpatient	1.Certification of Policyholder 2.Claim application form 3.Identification of insured 4.Case history, diagnose certificate, and hospital discharge certificate. 5.Inpatient receipt and expenses list	Dread Disease	1.Certification of Policyholder 2.Claim application form 3.Identification of insured 4.Case history, diagnose certificate, hospital discharge certificate (Inpatient treatment) 5.Test report related pathology, blood and image etc.
Outpatient/emergency	1.Certification of Policyholder 2.Claim application form 3.Identification of insured 4.Case history, diagnose certificate 5.Receipt, prescription and test report of outpatient/emergency 6.Proof of accident(Receiving treatment is caused by accident)	Disability	1.Certification of Policyholder 2.Claim application form 3.Identification of insured 4. Case history, diagnose certificate, hospital discharge certificate (Inpatient treatment) 5.Appraisal report of disability 6.Proof of accident(disability is caused by accident)
Accidental Medical treatment	1. Certification of Policyholder 2. Claim application form 3. Identification of insured 4. Proof of accident 5. Case history, diagnose certificate 6.Receipt, prescription and test report of outpatient/emergency 7.Inpatient receipt, hospital discharge certificate and expenses list (Inpatient treatment)	Death	1. Certification of Policyholder 2. Claim application form 3.Identification of insured, beneficiary and heir 4.Case history, proof of death, proof of cancellation of registered permanent residence and proof of burial. 5.Relationship proof of beneficiary, heir and insured; legal document of inheritance(beneficiary is not designated) 6. Proof of accident(death is caused by accident)
Hospital Income	1. Certification of Policyholder 2. Claim application form 3. Identification of insured 4. Case history, proof of sick leave provided by hospital and working organization 5. The copy of Inpatient receipt、expenses list		