

请填写并签署下列获取医疗信息的授权。

请参见《全球保》会员手册的第3.6章，其中概述我们在理赔审核时候，可能需要您提供进一步的医疗资讯。

如果您不允许我们合理获取这些重要医疗资讯，我们将不能作相关疾病进一步的理赔审核。

Please complete and sign the following authority for the release of your medical information.

We ask you also to refer to section 3.6 of your members' handbook which outlines the additional information you may be asked to provide in the event of a claim.

Please note that if you do not allow us reasonable access to this information, we may not be able to process your claim.

### 被保险人资料

#### Member Details

被保险人姓名:

Member name:

被保险人编号:

Membership number:

出生日期(日/月/年):

Date of birth (dd/mm/yyyy):

### 医疗机构资料

#### Medical facility details

医疗机构/主诊医生:

Medical facility/treating medical practitioner:

电邮地址: Email:

电话号码: Telephone number:

传真: Fax:

### 医疗资料

#### Medical details

本人/被保险人同意授权本人/被保险人提供过治疗的上述医疗机构/主诊医生提供以下医疗记录和机密医疗资讯给亚太财产保险有限公司/时康管理顾问(上海)有限公司或其授权的代表。

I/the member named above authorise the above medical facility/treating medical practitioner to release the following medical records and confidential information to Asia-Pacific Property & Casualty Insurance Co., Ltd./Now Health International (Shanghai) Limited or to its authorised representative:

完整记录 Complete record

治疗记录从(日/月/年)

Records of care from (dd/mm/yyyy)

到(日/月/年)

to (dd/mm/yyyy)

only

以下病症的治疗记录: Records of care concerning the following medical condition(s):

其他/请列出: Other. Please specify:

本人/被保险人同意授权上述本人/被保险人提供过治疗的主诊医生口述关于本人/被保险人的医疗记录

Authorisation to confer with above named treating medical practitioner orally about information in my medical record

### 提供医疗资讯授权

#### Authorisation

本人/被保险人明白可能被要求提供医疗资讯，同时，本人/被保险人明白可以拒绝此要求，但如果我这样做的话，这将无法受理我的索赔；

在此本人/被保险人同意亚太财产保险有限公司/时康管理顾问(上海)有限公司或其授权的代表可从以上医疗机构/主诊医生获取医疗资讯。

本授权书的副本或传真被视为有效文件。

I understand that I may have access to the medical information requested and may equally decline its release (preventing the assessment of my claim) and hereby consent to Asia-Pacific Property & Casualty Insurance Co., Ltd./Now Health International (Shanghai) Limited or to its authorised representative obtaining medical information from the above medical facility/treating medical practitioner.

A photocopy or facsimile of this authorisation shall be considered as effective and valid as the original.

签署(被保险人/授权代表) Signature of member/authorised representative:  
(父母/法定监护人/近亲) (parent/legal guardian/next of kin)

日期(日/月/年): Date (dd/mm/yyyy):

**请注意:** 亚太财产保险有限公司/时康管理顾问(上海)有限公司不会支付获取医疗报告/记录的费用。

请通过电子邮件, 电邮授权表至 CustomerService@now-health.com

**Note:** Asia-Pacific Property & Casualty Insurance Co., Ltd./Now Health International (Shanghai) Limited **will not pay for the release of any medical reports/records.**

Return this form by email to CustomerService@now-health.com

保险合同由亚太财产保险有限公司签发, 并委托时康管理顾问(上海)有限公司进行保单管理。亚太财产保险有限公司地址: 中国深圳市福田区中心区福华一路免税商务大厦29-30楼, 邮编: 518048时康管理顾问(上海)有限公司地址: 中国上海市虹口区吴淞路218号宝矿国际大厦11楼1103室-1105室, 邮编: 200080

Policies are issued by Asia-Pacific Property & Casualty Insurance Co., Ltd. Registered Office: 29-30F, Dutyfree Business Building, 1st Fuhua Road, Futian CBD, Shenzhen 518048, China. Policies are administered by Now Health International (Shanghai) Limited. Room 1103-1105, 11/F, BM Tower, No. 218 Wusong Road, Hongkou District, Shanghai 200080, China.