全球保理赔申请表
WorldCare claim form

Administered by: NOW HEALTH INTERNATIONAL

Insured by: RSA

第一部分：被保险人与病人资料
Section 1: Member and Patient Information

投保人姓名：**Planholder's** name:	保险计划编号：**Plan** number:
病人姓名：Patient's name:	会员编号：Membership number:
出生日期（日/月/年）：Date of birth (dd/mm/yyyy): / /	
电邮地址：Email address:	电话号码：Telephone number:
医生就诊/诊断原因： – 列出病症或医疗问题如腹部疼痛/脚部出现皮疹/眼部感染 Reason for doctor visit/diagnosis: – specify symptoms or medical problem e.g. abdominal pain/rash on foot/eye infection	
治疗所在国家： Country where **Treatment** took place:	治疗日期（日/月/年）： **Treatment** date (dd/mm/yyyy): / /
发生索赔时的币种： Currency claim incurred in:	被保险人希望在赔偿中使用的货币： Currency you would like your claim reimbursed in:
索赔总金额： Total claimed amount:	
服务类型：门诊 ☐ 日间留院 ☐ 住院 ☐ Type of service: **Out-Patient** **Day-Patient** **In-Patient**	服务类型：牙科 ☐ 生育 ☐ 眼科 ☐ 例行体检 ☐ Type of service: Dental Maternity Optical Routine check up
主治医生：牙医 ☐ 医生 ☐ 专科医生 ☐ 其他 ☐ 请说明： Attending physician: Dentist **Medical Practitioner** **Specialist** Other Please specify:	
是否因事故/损伤而索赔？是 ☐ 否 ☐ Is this claim due to **Accident**/injury? Yes No	如果是，请附上完整医疗资料。事故/损伤日期（日/月/年）： If yes, include complete medical information. Date of **Accident**/injury (dd/mm/yyyy): / /

第三方保险人 Third party insurers

如果部分费用可由第三方进行赔偿，（例如索赔的医疗状况或损伤与相关的人员或机构有关）请提供详情：
If some of the costs are recoverable from a third party (for example, if the **Benefits You** are claiming relate to a **Medical Condition** or injury caused by a person or organisation, or if **You** have cover on another insurance policy for this claim), please provide details:

第二部分：支付详情
Section 2: Payment details

请支付：被保险人 ☐ 医疗机构 ☐ Please pay: **Planholder** Provider		
请选择支付类型：银行转账 ☐ 支票 ☐ Please choose payment type: Bank transfer Cheque		
1. 银行转账 — 请填写所有详情以进行银行转账支付。* Bank transfer – please complete all details to enable bank transfer payments.*		
账户/收款人姓名： Account/payee name:	支付货币： Payment currency:	
银行名称： Bank name:	银行代码： Bank code:	分行代码： Branch code:
分行地址： Branch address:		
国际银行账号或账户号码： IBAN or account no.:	汇款路由代码 （如Swift或sort代码） Routing code (e.g. Swift or sort code):	
其他任何相关的信息：(例如：当地银行代码) Any other relevant information: (e.g. Local bank code)		
2. 支票**：收款人姓名 Cheque**: Payee name		
支票邮寄地址： Cheque mailing address:		
收款人电话号码： Payee's telephone number:		

* 我们确保所有的银行费用由我们支付，然而在某些情况，您的当地银行将向您收取服务费用，请与您的当地银行核实服务费收取情况。
** 如果您需要通过支票支付，请注意支票将会以普通邮寄发送。
* **We** endeavour to ensure that all bank charges are paid by **Us**; however on occasions **You** may incur a charge levied by **Your** own bank, over which **We** have no control.
** If **You** require payment via cheque, please note that this will be sent to **You** in the post, and may take some time to be received.

本人已经阅读第四部分中的声明及授权。本人同意并明白该声明及授权，任何索赔都应符合本人的保险计划的条款及条件。
I have read the declaration and authorisation in Section 4. I agree to the declaration and authorisation and understand that any claim for **Benefit** is in accordance with the terms and conditions of **Our Plan**.

本人同意并附上第四部份的的声明及授权 。
I will enclose Section 4 if anthorisation has been limited by me where available.

病人签名（**被保险人/投保人**）： Patient's signature (**Insured/Main Applicant**):	**日期**（日/月/年）： **Date** (dd/mm/yyyy): / /

第三部分：医疗资料，日间留院或住院治疗金额高于500美元的索赔（由负责治疗病人的医生填写）
Section 3: Medical information, Day-Patient and In-Patient claims over USD 500
(to be completed by the doctor responsible for the patient's **Treatment**)

病症： **Medical Condition**:	诊断ICD10代码：（如适用） Diagnosis ICD10 code: (if applicable)
基本病因详情： Details of any underlying cause:	
病人首次就医的具体时间？（日/月/年） When did the patient first see a doctor? (dd/mm/yyyy) / /	
治疗/药物详情： Details of **Treatment**/medication:	
手术详情（如有）： Details of operation (if any):	
	诊疗程序代码：（如适用） Procedure code: (if applicable)
医院详情（如适用）： **Hospital** details (if applicable):	治疗日期（日/月/年）： **Treatment** date (dd/mm/yyyy): / /
姓名： Name:	
地址： Address:	
入院日期（日/月/年）： Admission date (dd/mm/yyyy): / /	出院日期（日/月/年）： Discharge date (dd/mm/yyyy): / /

医生声明：
Medical Practitioner Declaration:
谨此声明，本人是病人的医生，就本人所知及所信，所填资料均正确无误。
I declare that I am the patient's **Medical Practitioner**, and that the particulars given are, to the best of my knowledge, true and correct.

姓名（正楷填写）： Print name:	官方印章： Official stamp:
签名： Signature:	
日期（日/月/年）： Date (dd/mm/yyyy): / /	

若被保险人的保险计划包含住院现金津贴：如果病人在医院渡过了一整夜而无需付费，请附上医院提供的确认函，并加盖医院印章。
门诊直付网络：保险人有可能会与相关医院商议直接付款。请在治疗前致电保险人的客户服务团队予以安排，号码为 +971 (0) 4450 1415。
If **Your Plan** includes a hospital cash **Benefit**: If the patient stayed in **Hospital** overnight without charge please include confirmation from the **Hospital** including the **Hospital** stamp.
Direct Billing: It may be possible for **Us** to arrange direct settlement with the **Hospital** involved. Please call **Our** Customer Service team before **Treatment** to arrange this on +971 (0) 4450 1415.

第四部分：声明
Section 4: Declaration

时康国际也许会就您可能有兴趣的其他医疗保险产品及服务通过信函、短信或电子邮件与您联系。如您不希望我们如此行事，请勾选本方框☐。

We may contact **You** with details of other products and services which may be of interest to **You**. **You** may be contacted by post, telephone or email if appropriate. If **You** do not wish this to happen please tick this box☐.

声明

特此声明，本人是病人/病人的监护人*（如果病人小于 16 岁）（*请删去不适用者）。

本人希望获取索赔赔偿，并声明就本人所知及所信，所提供资料均真实、正确及完整，即使并非本人亲笔书写。

本人明白，本人为欺诈或企图欺诈时康国际而提供错误、不完整或有误导性的事实或数据（误导事实）属违法。惩罚包括监禁、罚款、拒绝承保、取消或增加保险费、取消赔偿及法定损害赔偿。

本人同意上述资料保障声明，并明白该索赔申请应符合《全球保》保险计划的条款及条件。

由于本人已阅读查看医疗报告1988 年法案告知本人权利方面的声明，并同意时康国际必要时可从医生处查阅医疗报告，所以时康国际可以处理我的索赔要求。

本人（不）*希望在医疗报告送达时康国际之前查看医疗报告。*如果您希望查看报告，请删除“不”字。

本人谨同意授权治疗过本人或向本人提供过建议的任何医生和/或医院向时康国际提供其可能要求的与该索赔相关的任何资料。

填妥并由病人与医生签名后（当需要时），请将此表及随附的发票和付款收据寄回至Now Health International Gulf Third Party Administrators LLC, PO Box 502163, Al Shaiba Building, Dubai Outsource City, Dubai, UAE.

Declaration

I hereby declare that I am the patient/patient's guardian*(if the patient is under 16 years of age) (*please cross out if not applicable).

I wish to claim **Benefit** and declare the information I have given is, to the best of my knowledge, true, correct and complete even if it is not in my own handwriting.

I understand it is unlawful for me to knowingly provide false, incomplete or misleading facts or information (misrepresentations) to Now Health International for the purpose of defrauding or attempting to defraud Now Health International or the **Underwriters**. Penalties may include imprisonment, fines, denial of coverage, loss of or increase in premium, loss of **Benefits** and legal damages.

I agree to the data protection declaration above and understand that cover is provided in accordance with the terms and conditions of WorldCare **Plan**.

I have read the statement notifying me of my rights under the Access to Medical Reports Act 1988 and consent to Now Health International seeking medical reports if needed from my **Medical Practitioner**, so Now Health International can deal with my claim for **Benefit**.

I do (NOT)* wish to see the medical report before it is sent to Now Health International. *Delete the word NOT if **You** wish to see the report.

I hereby consent to authorise any doctor and/or **Hospital** who has treated or advised me to provide Now Health International with any information they may require in connection with this claim.

When completed and signed by the patient and **Medical Practitioner** (when appropriate), please return this form and the accompanying invoices and payment receipts to: Now Health International Gulf Third Party Administrators LLC, PO Box 502163, Al Shaiba Building, Dubai Outsource City, Dubai, UAE.

重要信息：

请使用正楷字体填写本理赔申请表，并于首次治疗日期后六个月内提交给保险人（除非条件不允许）。

如果被保险人的门诊医生费用或日间留院和住院治疗索赔总金额（每名被保险人于每个保险期间的每个医疗状况）少于美元500，被保险人只需填写第一部分和第二部分，并在向保险人提交理赔申请表时附上被保险人的就诊收据 。被保险人可以将理赔申请表和收据扫描及电邮至MEAService@now-health.com 或传真至 +971 (0) 4450 1416 。请保留原有文件的副本，保险人可能会要求被保险人提供该类副本 。

如果被保险人的日间留院或住院治疗索赔总金额（每名被保险人于每个保险期间的每个医疗状况）超过美元500，请确认第三部分由医生填写 。保险人还必须查看收据副本 、诊断报告和出院报告（如果被保险人曾经是日间留院或住院病人）。此外，您可以将理赔申请表 、收据 、诊断报告和出院报告扫描及电邮至MEAService@now-health.com 或传真至 +971 (0) 4450 1416 。请保留原有文件的副本，我们可能会要求您提供该类副本 。

被保险人可以在被保险人的网上安全组合区随时在线跟踪理赔的进度 。请使用被保险人的用户名和密码登入www.now-health.com 。

如果被保险人对该表格或保险的其它方面有任何疑问，
请致电 + 971 (0) 4450 1415 或电邮至 MEAService@now-health.com 。

Important information:

Please complete the claim form in BLOCK CAPITALS and submit it to **Us** within six months of the initial **Treatment** date (unless this is not reasonably possible).

For all **Out-Patient Treatment** and if the total amount **You** are claiming (per **Insured Person**, per **Medical Condition**, per **Period of Cover**) for **In-Patient** or **Day-Patient Treatment** is less than USD 500, **You** only need to complete Sections 1 and 2 and include a copy of **Your** receipt when **You** send **Us Your** claim form. **You** can scan **Your** claim form and receipt and email it to MEAService@now-health.com or fax it to + 971 (0) 4450 1416.
Please keep a copy of the original documents in case they should be required by **Us**.

If the total amount **You** are claiming now or have claimed for **Day-Patient** and **In-Patient**, (per **Insured Person**, per **Medical Condition**, per **Period of Cover**) is over USD 500, please ensure Section 3 is completed by the treating **Medical Practitioner**. **We** must also see receipts, diagnostic reports and discharge reports (if **You** have been a **Day-Patient** or **In-Patient**) for claims over this amount. **You** can scan **Your** claim form and receipts/diagnostic reports/discharge reports and email them to MEAService@now-health.com or fax them to + 971 (0) 4450 1416. Please keep a copy of the original documents in case they should be required by **Us**.

You can track the progress of **Your** claim online at any time in **Your** online secure portfolio area. Log in at www.now-health.com using **Your** username and password.

If **You** have any questions about this form or any other aspect of **Your** cover, please call **Us** on + 971 (0) 4450 1415 or email us at MEAService@now-health.com.

Plans issued in the United Arab Emirates (UAE) are insured by
Royal & Sun Alliance Insurance Middle East B.S.C. (c) and
are administered by Now Health International Gulf Third Party Administrators LLC.
Registered address: 2348 Sky Tower, Al Reem Island, P.O Box 132168, Abu Dhabi, U.A.E
Regulated by the UAE Federal Insurance Authority with license number 11169.
Royal & Sun Alliance Insurance Middle East B.S.C. (c) registered under
UAE Federal Law dated April 1,1997 (Registration No 65).

注意事项：本理赔申请表的中文译本仅供参考，如有争议，应以英文版本为准。
Note: The Chinese translation of the applicaiton form is for reference only, in case of any dispute, the English version shall prevail.