Cigna & CMB Life Insurance Co., Ltd. International Medical Claim Form — For Reimbursement Claims

招商信诺 Cigna & CMB 保险 • 健康 • 财富

*Type of Application: ☐ Outpatient ☐ Inpatient ☐ Wellness ☐ Vision ☐ Maternity ☐ Dental

In this form, items with * are mandatory. This form is to be well and truly completed by the insured person or his/her proxy.

Full Name of the Policyholder_____ Main Insured/Employe_____

SECTION A: BASIC INFORMATION OF THE INSURED PERSON

Applicant		Insured /Patient (Leave this column blank, if the same person as Applicant)
*1 Name: *2 Gender: ☐ Male ☐ Female *3 Nationality:	Relationship with insured ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Others :_____	*1 Name : *2 Gender : ☐ Male ☐ Female *3 Nationality:
*4 Membership No. : ☐☐☐☐☐☐☐☐☐☐☐☐		*4 Membership No. : ☐☐☐☐☐☐☐☐☐☐☐☐
*5 Type of Identification: ☐ID Card ☐Passport ☐Other:_____		*5 Type of Identification: ☐ID Card ☐Passport ☐Other:_____
*6 No. of Identification Document: ☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐	*7 Term of Validity:	*6 No. of Identification Document: ☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐	*7 Term of Validity:
*8 Mailing Address : (please fill in Residential Address if it's inconsistent with Mailing Address)		*8 Mailing Address : (please fill in Residential Address if it's inconsistent with Mailing Address)
*9 Mobile Phone No.: ☐☐☐☐☐☐☐☐☐☐☐		*9 Mobile Phone No. : ☐☐☐☐☐☐☐☐☐☐☐
*10 Email Address: _____ Note: Please make sure your contact information is correct, as the notification, reminding and settlement letter for your claim will be sent to your above Mobile Phone No. and Email Address by SMS and Email.		*10 Email Address: _____

*11 Has the insured person received full or partial reimbursement for the medical expense that is claimed from plans other than this one, such as the social insurance, governmental coverage and other insurance plans through insurance companies including Cigna & CMB?

☐ Yes 是 ☐ No 否

*12 If your answer for the question in Article 11 is "Yes", please give us the following details (full name of the insurance company, policy number, claim number, and claim amount)

*If claim reimbursement amount exceeds RMB 10,000 or other currencies equivalent, please fully complete the Section A and provide the copy of the valid identification of the Applicant/Employee and Beneficiary/Insured (i.e., ID card (both sides), passport).

*SECTION B: TREATMENT INFORMATION

Service Date	Hospital	Diagnoses or Symptoms	Invoice Amount	Invoicing Currency

*SECTION C: BANK ACCOUNT INFORMATION

1 Selection of Collection Currency*

☐ RMB ☐ HKD ☐ SGD ☐ USD ☐ EUR ☐ Others, please give the details _____

Note: For any and all claims incurred in the mainland of China, the insurance benefits will be paid in RMB.

2 Information of Receiving Bank Account

Account Name*_____ Account No.*_____

(Please pay attention to the Chinese characters or English or Pinyin name (Romanization of Chinese characters), capital letter or small letter, punctuations and space.

Bank Name*_____ Bank Branch Name*_____

Swift Code_____ IBAN No. _____

Do you agree to transfer the insurance benefits in this account?* ☐ Yes ☐ No

Note: We will not charge you any service fee for the transfer of your insurance benefits, but your receiving bank may do so. Please contact your receiving bank for the details thereof.

Anti-fraud Prompt and Declaration of Authorization

Honesty is a fundamental principle under insurance contracts. People involving in insurance-related fraud can be held accountable as follows:

【Criminal Penalty】: People engaging in insurance-related fraudulent actions which have reached the level of constituting crime can be subject to criminal penalty of criminal detention or fixed-term imprisonment, which are combined with criminal fine or confiscation of property. People who assess insurance incidents or provide related evidence intentionally provide fictitious evidential documentation to facilitate the commitment of fraud by others would also be criminally penalized as accomplice under the crime of insurance fraud.

【Police Sanction】: People engaging in insurance-related fraudulent actions which have not reach the level of constituting crime can be subject to police sanctions of detention up to 15 days and a fine up to RMB 5000. People who assess insurance incidents or provide related evidence intentionally provide fictitious evidential documentation to facilitate the commitment of fraud by others would also be subject to corresponding sanctions.

【Civil Liability】: Failure to perform the duty of truthful disclosure, either intentionally or due to gross negligence, could result in the insurance company's refusal to pay or reimburse claims.

Authorization and Statement

1、I hereby declare that the above statements and facts are correct and I have read through and understood the Anti-fraud Prompt. If I get involved in or carry out any insurance fraud, Cigna & CMB shall have the right to share relevant claim information with the whole insurance industry.

2、I hereby agree and authorize Cigna & CMB to process my personal information for the purpose of performing insurance contracts, providing services, and fulfilling legal obligations. Detailed authorization as following:

1) I acknowledge and agree that personal information includes Name, Gender, Nationality, Occupation, Address, Contact Information and ID Card Information, as well as sensitive personal information such as Biometric Characteristics, Medical Health.
2) I acknowledge and agree that Cigna & CMB and institutions and individuals authorized by Cigna & CMB to interrogate, retrieve, extract, copy or access in any other methods any materials related to applications for settlement of claims of me or the insured from any social medical insurance or new rural cooperative medical insurance agencies, public security organs, judicial administrative organs, medical institutions, insurers and re-insurance companies, other financial institutions and agencies concerned, as well as any individuals with intimate knowledge of health, life and financial status of the insured and relevant accidents. I am willing to bear all legal liabilities thus caused. A Photostat copy of this authorization shall be considered as effective and valid as the original.
3) Cigna & CMB have the right to use or provide my personal information to the cooperative institutions necessary for the provision of services to Cigna & CMB, for the purpose of performing insurance contracts, providing services.
4) Cigna & CMB can provide my personal information to the judicial authorities, People's Bank of China, China Banking and Insurance Regulatory Commission and its dispatched agencies and other regulatory authorities, or third parties designated by former regulatory authorities, insurance industry associations, trade associations and other relevant organizations for the purpose of fulfilling legal obligations.
5) In case of any discrepancies in my name, gender, DOB, certificate No., certificate type, certificate validity, nationality, job-related information, and Tax ID-related information from the previous information saved by Cigna & CMB, Cigna & CMB may update the above information with my consent for the said authorization. With respect to the personal information of other subjects provided by me, I confirm that I have obtained authorization from these subjects.
6) I acknowledge and agree that Cigna & CMB will do its best to protect clients' personal information and require its cooperative institutions to assume corresponding confidentiality obligations.
7) I acknowledge and agree that Cigna & CMB will provide my personal information to the overseas entities to perform above-mentioned services, if this claim service application involves overseas medical services, emergency treatment, etc.

3、I agree that it shall be deemed as my receipt of compensation from Cigna & CMB if the compensation has been successfully remitted to my bank account via bank transfer.

4、I declare that the above information I provided for this consultation is true and I also hereby confirm that I have reviewed and signed for all other related information including medical description that doctor recorded. I understand that changing these information may lead to a payment delay, partially denial or whole denial.

5、I understand that Cigna & CMB may settle the medical expenses with medical providers through direct billing, but the direct billing amount does not represent the final claim conclusion. I acknowledge that if the direct billing amount exceeds the final amount of insurance benefits, I am responsible for any fees my insurance policy does not cover, Cigna & CMB also have the right to deduct such part from future payment of insurance benefits or require a refund from me. If it could not be refunded in due time, my direct billing services and other related policy services will be affected.

*Handwritten Signature of the Insured Person (or Parent/Guardian if under18)

*Date

SECTION D: MEDICAL INFORMATION

To be completed by Treating Physician legibly and authenticated with his/her signature and seal or the official practice stamp of the hospital. This section can be left blank if the claim information are accompanied by relevant medical information.

1 Please state the date on which the insured person first consulted you for this condition

2 Date the symptoms first occurred

3 Please give your diagnosis of the illness/injury

4 Please give the details of treatment, medication names and instructions for medication dosage

*Handwritten Signature of Treating Physician

*Date

Please return your completed original claim form to:

Online Submission	Mail / Express
If the reimbursement your claimed is equal or less than RMB3,000, you can submit it via our APP “Perfect Life” Download address: hms.cignacmb.com/s/FW0E. NOTE: Please ensure the document uploaded is clean and clear; please keep the original claim documents for random check purpose.	You can fill out the claim form and submit them to: 8/F, Building 2, LuJiaZui Century Financial Plaza, 759 South YangGao Road, Pudong New Area District, Shanghai, China, PRC, 200127 Tel: 021-61871288 You also can submit claim incurred in USA to: Cigna Global Health Benefits, PO BOX 15050,Wilmington, DE 19850-5050 USA

Annex: Information Required for Claim

Information Required for Claim						
Information Required for Claim	Outpatient	Inpatient	Dental	Wellness	Vision	Maternity
Claim Form (containing the complete information of the receiving bank and signatures)	★	★	★	★	★	★
Original Medical Invoices (excluding those of Online Submission of Small Claim)	★	★	★	★	★	★
List of Expenses/Breakdown	★	★	★	★	★	★
Medical Records and Reports	★	★	★		★	★
Discharge Summary		★				
Third-party Authorization (if the payee is not Main Insured or Parents/Guardian if Insured under 18)	★	★	★	★	★	★
Identification of the Insured Person (which applies if the claim for reimbursement amounts to over RMB 10,000 or other currencies equivalent)	★	★	★	★	★	★
Eyeglass Prescription					★	
Claim Division Sheet	★	★	★	★	★	★

- Identification of the Insured Person: If the single claim for reimbursement amounts over RMB 10,000 or foreign currencies equivalent to USD 1000, we require a copy of the insured person’s valid identification (i.e., ID card (both sides), passport or driving license), or birth or household registration certificate (if the insured person is under age).
- The foregoing are the general information required for claim, and if the claim information is incomplete, we shall be entitled to require the claimant to give us more relevant information.
- Claim Division Sheet: If the expense for which this claim is made has been reimbursed by another insurance company, we require the claim division sheet issued by such insurance company.