STARR
史带财产保险股份有限公司
全 球 保 险 与 投 资

意 外 健 康 险 索 赔 申 请 表
Accidental and Health 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

保险单号码 Policy Number	(旅行险类 Travel Insurance only)行程日期 Trip period： 由 From 至 To 目的地/Destination：			
姓名 Name（被保险人 Insured/索赔人 Claimant）	性别 Sex	年龄 Age	职业 Occupation	身份证/护照号码 ID/Passport Number
通讯地址 Address	邮政编码 Postal Code	联系电话 Phone	电邮地址 Email	

理赔授权 Claim Authorization （如适用 where applicable）

本人__________________，谨授权__________________（被授权人证件号/组织机构代码证号______________________）向史带财产保险股份有限公司全权办理相关理赔手续。

I/We ________________ , hereby authorize ____________________(Delegated person‘s ID number /Company code _________________________) to deal the claim procedure with Starr Property & Casualty Insurance (China) Company Limited on behalf of me/us.

授权人签字 Authorized Signature:	**被授权人 Delegated Signature:**

保险事故 Incident Details

事故地点 Loss Location	事发日期 Loss Date	时间 Time
事故描述 Loss Description		
证人姓名 Witness	地址 Address	联系电话 Phone /电邮 Email

如果此次损失可向其他保险公司索赔，请说明 If this incident can be claimed through other insurance company, please state

保险公司 Insurance company:	保险单号码 Policy number:
索赔项目 Claim item:	申请或获赔金额 Claimed/Settled amount

银行帐户资料 Bank Details

赔款将通过银行转帐支付。所有索赔申请，均须填写此部分 Settlement will be credited to your account by bank transfer, please provide the following details:

转账授权 Fund Transfer Authorization （如适用 where applicable）：

本人__________，谨授权史带财产保险股份有限公司将以上保险事故的全部理赔款项划入本授权人指定的____________________（请填写收款人或收款单位的名字）的以下账户。收款人证件号（或组织机构代码）：________________________。

I/We __________ , hereby authorize Starr Property & Casualty Insurance (China) Company Limited to release the indemnity of above incident to the below bank account of ________________ (please fill the name of payee) on behalf of me/us. Payee’s ID number （company code）: ____________________.

授权人签字 Authorized Signature:	**收款账户所有人签字 Payee Signature:**	
户名 Payee Name：	开户银行(银行名/分行)Bank(Name/Branch)：	账号 Account Number：

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√	索赔项目 Claim Item	索赔金额 Claim Amount
	身故、残疾	
	意外医药费	

保险反欺诈提示 Insurance Anti-Fraud Alert

诚信是保险合同基本原则, 涉嫌保险欺诈将承担以下责任：

Integrity is the basic principle of insurance agreements. Being involved in suspicious insurance fraud may lead to the following liabilities:

【刑事责任】进行保险诈骗犯罪活动，可能会受到拘役、有期徒刑, 并处罚金或者没收财产的刑事处罚。保险事故的鉴定人、证明人故意提供虚假的证明文件, 为他人诈骗提供条件的, 可被以保险诈骗罪的共犯论处。

[Criminal Liability] Anyone who is involved in insurance fraud criminal activities may be subject to criminal penalties including detention or fixed term imprisonment with fine or forfeiture. The identifiers or witnesses of the insurance accident, who provide mendacious documents intentionally or assistance to others who is involved in the insurance fraud, should be considered as accomplices in the offense of insurance fraud.

【行政责任】进行保险诈骗活动, 尚不构成犯罪的，可能会受到 15 日以下拘留、5000 元以下罚款的行政处罚；保险事故的鉴定人、证明人故意提供虚假的证明文件，为他人诈骗提供条件的，也会受到相应的行政处罚。

[Administrative Liability] Anyone who is involved in insurance fraud activities without constituting a crime may be subject to administrative penalties including retention for no more than 15 days or fine for no more than RMB 5,000. The identifiers or witnesses of the insurance accident, who provide mendacious documents intentionally or assistance to others who is involved in the insurance fraud, may be subject to corresponding administrative penalties.

【民事责任】故意或因重大过失未履行如实告知义务，保险公司可能不承担赔偿或给付保险金的责任。

[Civil Liability] Where the client fails to perform the obligation of telling the truth intentionally or for gross negligence, the insurance companies may not be liable for paying indemnity or insurance money.

声明、授权及签署 Declaration, authorization and signature

本索赔申请表签署人谨此声明，以上陈述绝无虚假和隐瞒。本人明白，史带财产保险股份有限公司（“贵公司”）向本人提供本表、其代表为本人填写本表格、或接受或保留任何索赔文件，均不会影响保险合同任何条款的效力。**The undersigned declare that the above statements are fully and truly made. I understand that the furnishing of this form to me, its preparation by any representative of the insurance company, or taking or retaining any claims documents, shall not constitute its waiver of any of the conditions of the policy.**

本索赔申请表签署人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；即使本人/被保险人死亡或丧失能力，本授权仍然对本人及被保险人之继承人及受让人具有法律约束力。本授权之复印件与原件具有同等效力。

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 minor)： 与未成年人关系 Relationship： 日期 Date：