IMG EUROPE LTD
INTERNATIONAL MEDICAL GROUP®

Ping An GlobalSelect®
International Healthcare Insurance

中国平安 专业·价值 PING AN OF CHINA

Claim Filing Instructions & Claim Form

Claim Filing Instructions

- Please follow these instructions prior to filling a claim and when completing the Claim Form. Assistance is also available from the Plan Administrators at the telephone numbers listed below.

- If you have already received treatment:
  - If this is a new claim, complete *ALL PARTS* of the Claim Form. If treatment was received in the United States, you do not need to complete PART C.
  - If this is a continuing claim, complete PARTS A, and D. If treatment was received outside of the United States, please also complete PART C.
  - Attach all original itemised bills, statements and invoices for services and supplies.
  - Please make certain that all documents indicate claimant's name, date of service, diagnosis and the itemized charges.

Mail the completed form to:

In China (including Hong Kong & Macau)	Outside of China
Ping An Property and Casualty Insurance Company of China, Ltd. **(Address & contact of various branches concerned)** **For additional assistance:** **Tel:** **Fax:** **E-mail:**	**IMG Europe Ltd.** **36 - 38 Church Road** **Burgess Hill** **West Sussex RH15 9AE** **England** **For additional assistance:** **Tel: +44 (0) 1444 46560** **Fax: +44 (0) 1444 465550** **E-mail: claims@imgeurope.co.uk**

- If the medical provider rendering treatment or supplies to you has agreed to "Direct Billing Service," and you choose to use direct billing, please complete the "Authorization Form for Direct Billing Services" and the Claim Form. Then, request the medical provider to submit its billing statement, medical record documentation, Authorization Form for Direct Billing Services and Claim Form to us.

- Our goal is to process your claim quickly, accurately and efficiently. In order to achieve this, the Claim Form must be fully and accurately completed. Failure to do this will result in processing delays.

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Claim Form

(There are four parts to this form - A, B, C & D. Please carefully review the instructions below.)

- If this is a new claim, complete *ALL PARTS* of the Claim Form. If treatment was received in the United States, you do not need to complete PART C.
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- Please make certain that all documents indicate claimant's name, date of service, diagnosis and the itemized charges.

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Notice: Any false statement, concealment or fraud shall render this insurance null and void and all claims hereunder shall be forfeited.

PART A - To be completed and signed by the Claimant for all claims.

Claimant/Patient Name: (as appears on ID card)		
Male Female	Date of Birth: (dy/mth/yr)	
Claimant's Relationship to the Insured Person	Self Spouse Child Other	
Name of Insured Person: (as appears on ID card)		
Male Female	Date of Birth: (dy/mth/yr)	
Home Country Address:		
Current Address:		
Home Phone:	Work Phone:	E-mail:
Group # (if applicable):	ID# :	
Are you in school full-time Yes No		
If yes, please provide name of school and the address:		
Are you a U.S. Citizen Yes No		
How many months of the year are you in the U.S.?		

If Claimant is covered by another plan, complete items below.

Name of Insured Person: (as appears on ID card)		Date of Birth: (dy/mth/yr)	
Group # (if applicable):		ID# :	
Mailing Address		Name of other carrier:	
City		Carrier Address	
City	Postal Code	City	
Name of Employer		State	Postal Code

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PART B - To be completed by the Claimant for new claims only. (If you need additional space, please attach a separate sheet.)

1. How did the condition begin? State fully all symptoms and describe the condition in detail from the beginning.
   For accidents, include how, when and where the accident occurred.

2. When did the first symptom of this condition begin? State the exact date if possible. (dy/mth/yr)

3. Have you ever had or been treated for this type of injury or illness before? Yes No

4. List all the names and addresses of the doctors/hospitals you have seen for this condition.

5. What ailments, diseases, illnesses or injuries have you experienced during the last five years?
   Please provide the name and/or description of each condition, dates and name and address of the attending physician(s).

6. Is this condition the result of an accident or illness:

   a. Related to employment? Yes No
      If yes, are you applying for Worker's Compensation benefits? Yes No

   b. Involving a motor vehicle? Yes No
      If yes, please list the names of involved parties, insurance company and policy numbers.

   c. Was a police report filed? Yes No
      If yes, please identify the Police Department where it was filed.

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PART C - Complete for all treatment received outside of the United States

Date of service mm/dd/yr	Provider	What type of service/name of drug provided?	What was the illness/injury?	City/ Country	Type of Currency paid or billed	Total Charge paid or billed	Converted to RMB	Office use only

PART D - Authorisation (To be completed by the Claimant for all claims)

I verify that all information contained in this form is true, correct and complete to the best of my knowledge.

I authorise any licensed doctor, practitioner of the healing art, hospital, clinic, health related facility, pharmacy, government agency, insurance company, group policyholder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or the financial or employment status of the insured named below, to provide this information to Ping An Property and Casualty Insurance Company of China, Ltd. or any agent or administrator acting on its behalf.

I understand that I have the right to receive a copy of this authorisation upon request. A copy of this shall be as valid as the original. This authorisation is valid for twelve months from the date signed.

Print Name of Insured : ____

Signature of Insured/Guardian: ____ Date : __________________________

AUTHORISATION : I authorise payment of medical costs to the doctor or other supplier of services submitting the attached bills.

Signature of Insured/Guardian: ____ Date : __________________________

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PRIVACY AND CONFIDENTIALITY RELEASE FORM

By completing this form, you are providing your consent to Ping An Property and Casualty Insurance Company of China, Ltd. or any agent or administrator acting on its behalf, to discuss your claim activity with the person(s) listed below. Without this release form, Ping An Property and Casualty Insurance Company of China, Ltd. or any agent or administrator acting on its behalf, cannot discuss your claims activity with anyone other than your physician(s) or provider(s) of service.

I authorise Ping An Property and Casualty Insurance Company of China, Ltd. or any agent or administrator acting on its behalf, to discuss my claim activity with ____.
This authorisation is valid for ________ months from the date signed (not to exceed a 12-month period).

I give Ping An Property and Casualty Insurance Company of China, Ltd. or any agent or administrator acting on its behalf, permission to release any or all of the following information:

(Please select and initial)

__________ All financial and claim information related to medical bills or the Claim Form.

__________ Provider name, date of service, total charge, total paid and date of payment.

__________ Insurance ID number

Under no circumstances can Ping An Property and Casualty Insurance Company of China, Ltd. or any agent or administrator acting on its behalf release medical information obtained from your physician or provider of service to you or anyone. Your medical information has been disclosed to us from your physician of service and we are prohibited by law from further disclosure. Please contact your physician or provider or service for your medical information.

______________________________________ ______________________________

Print Patient Name Insurance ID Number

____

Signature of the Patient of Insured Person if the patient is a minor child

____

Date

Please provide your current mailing address:

Street Address	
City	State, Country, Postal Code

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