HEALTH INSURANCE CLAIM FORM AND/OR PRIOR APPROVAL REQUEST 健康保险索赔表及/或预批申请表

SOVEREIGN

This form **must be** completed in English (please print clearly)
请务必用英文填 写 (请用大写字母填写工整)

If you need help filling out this form please contact Sovereign on 0800 500 108
如果您在填表时需要帮助，请联系Sovereign保险公司，电话0800 500 108

Are you applying for prior approval? 您是要申请预批吗? ☐ Yes 是 ☐ No 否

Would you like to receive your prior approval confirmation letter by email? 您希望通过电子邮箱接收您的预批确认函吗? ☐ Yes 是 ☐ No 否

Is your claim ACC related? (If you answered 'Yes' please attach your ACC decision letter) 您的索赔与ACC有关吗? (如果回答"是"，请附上ACC的理赔决定函) ☐ Yes 是 ☐ No 否

Have you attached a pre-printed bank deposit slip? 您是否已附上一张银行印制的存款单? ☐ Yes 是 ☐ No 否

Is your referral letter attached? (If your referral letter does not include the below, please have your doctor complete section 5 of this form) 您的转诊介绍信是否已附上? (如果您的转诊介绍信不包括以下内容，请找您的家庭医生填写本表的第5栏) ☐ Yes 是 ☐ No 否

Please ensure your referral letter contains the following:
请确保您的转诊介绍信包含以下内容:

☐ Initial consultation date 初诊日期
☐ History of condition 个人病历
☐ Treatment received 接受的治疗

Please attach all original itemised accounts or receipts if you are claiming a reimbursement 如果您索赔赔付金，请附上所有原始账户明细或单据。 ☐ Yes 是 ☐ No 否

1 Policy owner(s) details 保单所有人详情

Policy number 保单号

Policy owner 1 保单所有人1

Mr/Mrs/Miss/Ms 先生/夫人/小姐/女士
First name(s) 名 | Last name 姓

Mailing address 邮寄地址

Telephone 电话
Home 住宅电话 ( ) | Business 工作电话 ( )
Mobile 手机 ( )

Email 电子邮箱

Date of birth 出生日期 / /

Policy owner 2 保单所有人2

Mr/Mrs/Miss/Ms 先生/夫人/小姐/女士
First name(s) 名 | Last name 姓

Mailing address 邮寄地址

Telephone 电话
Home 住宅电话 ( ) | Business 工作电话 ( )
Mobile 手机 ( )

Email 电子邮箱

Date of birth 出生日期 / /

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2 Claimant details
索赔人详情

Patient (claimant) details
病人（索赔人）详情

Mr/Mrs/Miss/Ms
先生/夫人/小姐/女士

First name(s) 名 | Last name 姓

Mailing address
邮寄地址

Telephone
电话

Home 住宅电话 ( ) | Business 工作电话 ( )

Mobile 手机 ( )

Email
电子邮箱

Date of birth
出生日期 / /

3 Claim details
索赔详情

Details of the condition or symptoms which have resulted in this claim (please be specific)
引起本索赔的详细病情或症状
(请填写具体)

Have you claimed for this condition before?
您以前是否就这种病症索赔过?

☐ Yes 是 ☐ No 否

Claim number (if known)
索赔号 (如有的话)

Symptoms started 症状开始日期 / /

Sought medical advice 就诊日期 / /

Treatment performed/to be performed (please delete one if not applicable)
已作治疗或拟作治疗
(请删除不适用的一项)

Name of provider/facility where treatment is to be performed
拟作治疗的机构或单位名称

Date of admission
住院日期 / /

Date of discharge
出院日期 / /

4 Declaration and consent
申明及同意

This claim form collects personal information about you (and any Life Assured for whom you are claiming under your Policy) for the purpose of assessing the insurance claim(s) under your policy.
为了对您保单下的保险索赔进行评估，本索赔表将收集您的个人资料（以及您就保单中进行索赔的受保人个人资料）。

The intended recipient of this information is Sovereign Assurance Company Limited ("Sovereign") and/or any of its related entities, their officers, their advisers, their agents and reinsurers and the information collected will be held at Sovereign's head office, 74 Taharoto Road, Takapuna and by Sovereign's data storage providers, including cloud-based data storage providers (whether in New Zealand or elsewhere). Sovereign will take reasonable steps to keep such information secure. Sovereign may be required to disclose personal information if disclosure is required by law, including laws of other jurisdictions, for example to government and regulatory authorities. Failure to provide the requested information or provision of incorrect information may result in your claim being declined or unable to be assessed. You and any Life Assured have the right to request access to, and correction of, your respective personal information at any time.

本资料收集者为 Sovereign 保险有限公司（"Sovereign"）及/或其它有关的实体、职员、顾问、代理商和再保险商。
所收集的资料将在本公司的总部保管，公司总部地址为：74 Taharoto Road, Takapuna，且资料由 Sovereign 公司的数据存储服务商储存，包括云端数据存储服务商（不论在新西兰或其它地方）。Sovereign 将采取合理的步骤确保这些资料的安全。Sovereign 将依法，包括按照其它法定权力机构如政府和监管机构的要求透露有关您的个人资料。如果您未能提供所需要的资料或提供了错误的信息，则您的索赔将有可能被拒绝或无法进行评估。您和其他的受保人有权随时要求获取并改正各自的个人资料。

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As part of a health insurance claim with Sovereign, I, the Life Assured, consent and give authority to Sovereign and any of its related entities and agents to seek from, and for all and any of the following, their officers and employees, to disclose to Sovereign, their advisers, reinsurers and to any legal tribunal before which any question concerning the insurance may arise, any medical or other personal information affecting such insurance which they may hold in respect of me:

作为 Sovereign 健康险索赔的一部分，我，受保人，同意并授权 Sovereign 及其关联实体和代理商向下列机构和员工了解有关我投保险中可能出现的问题，以及他们可能掌握的会影响到本保险索赔的有关我的医疗情况或我个人的其他资料，同意并授权这些机构和员工向 Sovereign 及其顾问、再保险人和法庭透露上述与我有关的全部或部分资料。

- Registered Medical Practitioners and specialists;
  注册执业医师或专科医生 ；
- Laboratories;
  化验室；
- Counsellors, psychologists and therapists;
  咨询师，心理学家及理疗师；
- Dentists;
  牙医；
- Your adviser/broker/insurance agent;
  您的顾问/经纪人/保险代理人；
- Hospitals (whether public or private);
  医院（不论公立或私立）；
- Accident Compensation Corporation;
  事故赔偿公司（ACC）；
- Insurers (whether public or private);
  保险公司（不论公立或私立）；
- Government departments, agencies, organisations and enterprises.
  政府部门，机构，组织及企业 ；
- any other person or organisation which Sovereign reasonably considers may hold information about me relevant to this claim.
  Sovereign 合理认为可能掌握我个人与本索赔相关资料的其他个人或机构。

If you purchased your insurance through ASB Bank Limited ('ASB') please complete the following:
I consent to the disclosure of my claims information to ASB for the purposes of notifying ASB of issues or disputes arising in respect of my claim.
如果您是通过ASB银行有限公司（以下简称ASB）购买的保险，请填写以下内容：
我同意将我的索赔信息披露给ASB，用于告知有关索赔事宜所引发的问题或争议。

☐ Yes 是 ☐ No 否

I, the Policy Owner, hereby claim the benefit amounts payable on the basis of the statements and information provided by the Life Assured in this claim form which I believe to be accurate and complete in every respect. I understand payments approved by Sovereign will be forwarded to me on receipt of accounts specifying the service provided and the amount payable.
我，本保单所有人，根据本索赔表中受保人提供的陈述和资料，兹就应赔付的受益金额提出索赔，据我所知，这些陈述和资料各方面均准确完整。我明白，Sovereign 在收到列明所提供服务和应付金额的详细账目后，会将经批准的支付金额转拨给我。

I, the Life Assured, agree that a photocopy of this authority will be valid as an original.
我，受保人，同意本授权书的复印件与原件具同等效力。.

Please print full name of Claimant (Life Assured)
请用大写字母填写索赔人(受保人) 的姓名

If a claim is being made by a child under 16 years of age, a parent or guardian must sign on the child's behalf. Please insert parent's or guardian's full name and sign below.
如果索赔由十六岁以下的未成年人提出，其父母或监护人必须代替该未成年人签字。
请填写父母或监护人的全名并在下面签字。

Signature of Claimant (Life Assured)
索赔人（受保人）签字

Date 日期 / /

Please print full name of Policy Owner(s)
请用大写字母填写保单所有人姓名

Signature(s) of Policy Owner(s)
保单所有人签字

Date 日期 / /

5 Medical certificate (please print clearly)
医生证明书（请用大写字母填写工整）

To be completed by a Registered Medical Practitioner or Dentist (at client's expense) if no referral letter provided
如无转诊介绍信，由注册执业医师或牙医填写（费用由客户承担）

Name of client
客户姓名

Name and address of General Practitioner/Dentist
家庭医生/牙医的姓名和地址

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I confirm that I am the Patient's General Practitioner/Dentist and that I referred the Patient to the Specialist for tests, e.g. x-rays
我确认本人为病人的家庭医生/牙医，且将病人转诊给专科医生作检测，如x光透视

Date of referral 转诊日期 / /

How long have you been the patient's medical attendant?
您接待诊治病人有多久?

Medical condition requiring treatment
需要治疗的病情

Date of first medical examination by **any** Doctor/ Dentist for this condition
任何医生/牙医对这种病情进行初诊的日期 / /

Details of first medical examination by **any** Doctor/ Dentist for this condition and any subsequent consultations for this condition
医生/牙医对这种病情进行初诊及复诊的详情

Date of consultations 就诊日期

/ /

/ /

/ /

Details of the recommended treatment/test
医生/牙医对这种病情进行初诊及复诊的详情

Is this accident related?
这是否与事故有关？

Yes 是 No 否

If Yes, has an application been made to ACC?
(please provide details including ACC Claim number below)
如回答“是”，是否已经向ACC申请索赔？（请提供详情如下，包括ACC索赔号）

Signature of General Practitioner/Dentist
家庭医生/牙医签字

Date 日期 / /

Request for payment (please print clearly)
支付请求（请用大写字母填写清楚）

When the medical services for which you are claiming are completed, please attach all original itemised accounts and list below
如果您索赔的医疗服务已完成，请附上所有的原始账目明细及清单如下：

Policy number
保单号

Claim number (if known)
索赔号（如有的话）

Patient (Claimant)
病人（索赔人）

Return to
请回寄到

Sovereign Assurance Company Limited
Private Bag Sovereign
Victoria Street West, Auckland 1142

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Invoice enclosed (to be paid to provider)
所附的发票（要支付给医疗机构的）

Please note - payment will be made directly to the treatment provider unless receipts attached.
请注意——除非附上收据，医疗费将直接支付给医疗机构。

Provider of treatment (eg Doctors or Hospital) 医疗机构（例如医生或医院）	Invoice amount 发票金额
	$
	$
	$
	$
Sum of invoices 发票合计	$

Receipts enclosed (for reimbursement to you)
所附的收据（赔付给您的）

Provider of treatment (eg Doctors or Hospital) 医疗机构（例如医生或医院）	Receipt amount 收据金额
	$
	$
	$
	$
Sum of receipts 收据合计	$
Total value of claim (= sum of invoices + sum of receipts) 索赔总计金额（=发票金额+收据金额）	$

Reimbursement details (please note: reimbursement can only be made to a bank account, not a credit card)
赔付金详情（请注意：赔付金只能转入银行账户，不能转入信用卡）

Please provide bank account details for reimbursement. Please attach a pre printed bank deposit slip.
请提供接收赔付金的银行账户详情。请附上一张银行印制的存款单。

Name of Account 账户名

Bank 银行	Branch number 分行号	Account number 账号	Suffix 尾数

Signature(s) of Policy Owner(s)
保单所有人签字

Date
日期

/ / / /

公司地址
Sovereign House,
74 Taharoto Road,
Takapuna,
Auckland 0622

邮政地址
Private Bag Sovereign,
Victoria Street West,
Auckland 1142

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Freephone 0800 500 108
免费传真 0800 329 768
Freefax 0800 329 768

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网址 sovereign.co.nz
Web sovereign.co.nz

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