Pre-Authorization Form 团险预授权申请表

Insured Information **被保险人信息**	**General Information** **基本信息信息**			
	Name 姓名		Gender 性别	
	Date of Birth 出生日期		ID/Passport# 证件号码	
	Serial# 编号		Membership# 卡号	
	Begin of insurance 保单生效日期		End of insurance 保单失效日期	

Applied Medical Information **申请信息**	Hospital Name 医院名称	
	Category 治疗类别	
	Diagnosis 诊断	
	Procedure 治疗内容	
	Scheduled Date 预计治疗日期	
	Estimated Expenses 预计消费金额	
	Remark 备注	

Declaration and Authorization
声明及授权

I hereby declare that the above information is provided by myself and no material has been withheld and information given herein is true. I authorize that any doctors, hospitals, clinics, insurance companies, police institutes and public or private organizations that keep any medical history or records or knowledge of me who I have attended or may hereafter attend to disclose such information to Generali China Life Insurance Co. Ltd. for the purpose of assessing and processing insurance application, claims or subsequent services. I hereby agree that any personal information collected by the Company is provided and may be held, used, disclosed and transferred by the Company for the purpose of insurance, reinsurance, data processing and statistics. I, the beneficiary, authorize Generali China Life Insurance Company to transfer reimbursement into the bank account designated once treament completed.

本人经过仔细审阅后确认上述所填内容、答案及与之有关的资料均为本人亲自提供且完整并确实无误，无隐瞒或遗漏。本人授权任何医生、医院、诊所、保险公司、公安机关、任何公立或私立的组织单位，在任何时候均可以将有关被保险人的资料、报告或文件交给中意人寿保险有限公司及其代表，此授权书的副本与正本具有同样效力。本人同意中意人寿保险有限公司将有关被保险人的资料用于保险、再保险、数据处理及统计事宜。本人授权中意人寿保险公司（以下称“贵公司”）在本人接受治疗后将赔付款项划入本人或直付机构在贵公司指定的银行账户。

√ Signature of Patient or Guardian
被保险人或其法定监护人签名

Date
dd/mm/yy
日期