

Treatment Guarantee Form

PLEASE COMPLETE THIS FORM IN BLOCK CAPITALS

For your convenience, this form in PDF version is available on our website: www.allianz.cn/en/products/healthcare

Is this an extension to an existing Treatment Guarantee? Yes No
If 'Yes', please provide the Treatment Guarantee ID reference number

To the patient

Please ensure that you complete sections 1, 2, 3 and 5, and that your doctor completes all questions in section 4. Failure to complete this form fully will delay our ability to guarantee your treatment as we may have to revert to you or the medical provider for further information.

The patient's policy must be in force at the time of treatment. Please be advised that guarantee of payment is subject to the terms and conditions of the insurance policy and also subject to the medical assessment of all relevant documentation received, or yet to be received, by Allianz China General Insurance Company Ltd. in respect of this medical condition.

1 Patient section

To be fully completed by (or on behalf of) the patient.

Policy number
Mr. Mrs. Ms. Miss Other
Surname
First name
Date of birth

2 Contact details

Please specify who should be contacted regarding the progress of this Treatment Guarantee.

Contact 1

Name
Relationship to patient e.g. self, spouse/partner, parent
Telephone COUNTRY CODE AREA CODE
Mobile telephone COUNTRY CODE NETWORK CODE
Fax COUNTRY CODE AREA CODE
Email

Contact 2 (optional)

Name
Relationship to patient e.g. self, spouse/partner, parent
Telephone COUNTRY CODE AREA CODE
Mobile telephone COUNTRY CODE NETWORK CODE
Fax COUNTRY CODE AREA CODE
Email

3 Patient signature and release of medical records

I hereby authorize my medical practitioner, health professional or other relevant medical establishment to provide any health details or medical records that may be requested by Allianz China General Insurance Company Ltd., Allianz Worldwide Care (third party administrator), or their appointed representatives.

If a minor was treated, a parent or guardian should sign this section.

Patient's signature _____ Date | y | y | y | y | m | m | d | d |

To the medical provider

For covered members, we guarantee (subject to approval) payment of the expenses specified in this Treatment Guarantee Form in accordance with the following conditions:

- If additional treatment is required, Allianz China General Insurance Company Ltd. must be notified.
- The hospital should submit a copy of this Treatment Guarantee Form with the corresponding invoices to Allianz China General Insurance Company Ltd. within 30 days of patient discharge.
- If invoices are received more than 60 days after patient discharge, acceptance of liability for those expenses remains at the discretion of Allianz China General Insurance Company Ltd.

4 Medical certificate

To be fully completed by the medical provider.

Please tick the relevant treatment category: Medical Maternity Psychiatry Oncology Rehabilitation

For in-patient/day-care treatment:

Planned admission date | y | y | y | y | m | m | d | d |

For treatment in Germany (DRG) please confirm Base Price (Basisfallpreis) _____

Is a package price being offered? Yes No

If 'Yes', please provide the details of the package and price offered: _____

If 'No', please provide a breakdown of estimated costs including currency:

Hospital charges _____

Surgeon/physician fees _____

Anaesthetist fees _____

Estimated length of stay _____ night(s)/day(s) (delete as appropriate)

Hospital/facility name _____

Address (including country) _____

Telephone | COUNTRY CODE | - | AREA CODE | - | _____ |

Fax | COUNTRY CODE | - | AREA CODE | - | _____ |

Email _____

Details of attending/admitting physician:

Name _____

Telephone | COUNTRY CODE | - | AREA CODE | - | _____ |

Fax | COUNTRY CODE | - | AREA CODE | - | _____ |

Email _____

Date of first attendance for this condition? | y | y | y | y | m | m | d | d |

Date this condition was first diagnosed? | y | y | y | y | m | m | d | d |

On what date would the first onset of symptoms have been apparent to the patient? | y | y | y | y | m | m | d | d |

Details of referring physician:

Name _____

Telephone | COUNTRY CODE | - | AREA CODE | - | _____ |

Fax | COUNTRY CODE | - | AREA CODE | - | _____ |

Email _____

Date of referral | y | y | y | y | m | m | d | d |

Please send your fully completed Treatment Guarantee Form at least five working days prior to treatment by:

- Scan and email to: medical.services@allianzhealth.cn
- Fax to: (+ 86) 21 60424688
- Post to: Healthcare Team, Allianz China General Insurance Company Ltd., Shanghai Branch, Aurora Plaza 25F04, Fucheng Road 99, Pudong District, Shanghai 200120, People's Republic of China.

Treatment Guarantee is not required in advance of **emergency treatment**, however either you, your physician, one of your dependants or a colleague need to inform us about the hospital admission **within 48 hours of the event**.

Please note that our Helpline can accept Treatment Guarantee requests over the phone if treatment is due to take place **within 72 hours**. Please have as many details as possible ready to give over the phone, including the contact details of your doctor.

Please contact our Helpline if you have any queries:

4008866014 (if you call from China), (+ 86) 21 60424601 (if you call from outside China) or client.services@allianzhealth.cn.

Allianz China General Insurance Company Ltd. is the insurer and the inside mainland China administrator of this policy. The company is registered in China and regulated by the China Insurance Regulatory Commission. Registered Office: Unit 5101 & 5106-5108, CITIC Plaza, 233, Tianhe Beilu, Tianhe District, Guangzhou, China. Registered no: 440000400014237.

Allianz Worldwide Care Limited, part of the Allianz Group and registered in Ireland, is engaged by the insurer for the administration of the insurance policy outside mainland China. Allianz Worldwide Care Limited is regulated by the Central Bank of Ireland. Registered Office: 18B Beckett Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. Registered no: 310852.