安联康睿寰球医疗保险(团体) / International Health Plans for China

团体医疗险(司南计划)投保申请书 / GROUP HEALTH INSURANCE (COMPASS PLAN) APPLICATION FORM

扫描二维码关注我们的官方微信，收获更多适合你和家人的健康睿智生活方式的内容分享。
同时，我们还为您附上京东安联国际医疗险的保单详情，以及访问我们的医疗网络机构的便捷入口。
Follow us on WeChat for lots of great health and wellness articles for you and your family.
Via our WeChat profile you can also find information on our International Health solutions, and you can access our medical provider finder.

AllianzJD

1 投保须知 / NOTES FOR APPLICATION

a) 在填写团体医疗险投保申请书之前，请仔细阅读所附保险条款，特别是保险责任、免除保险责任和合同解除等关键条款。收到京东安联财产保险有限公司（以下简称‘本公司’）发出的新业务资料包时，请仔细阅读并检查相关文件。 如果有任何错误或遗漏，请立即通知本公司。/ Prior to completing this form, please carefully read the attached terms and conditions in the Group Health Insurance Contract, especially the sections about the benefit definitions, exclusions and policy cancellation. Upon receipt of the Company Health Insurance Pack, please read and check the documentation included: should there be any mistake or omission, please immediately notify Allianz Jingdong General Insurance Company Ltd (hereafter referred to as the 'Insurer').

b) 团体医疗险投保申请书需加盖投保单位公章并由投保单位授权代表亲笔签名。请用黑色或蓝黑色水笔认真填写，且请勿涂改。/ This form must be completed truthfully by the applicant company's authorised representative. Please use a blue or black pen to complete this form and do not alter the text. Once completed please sign and stamp with the applicant company's official seal.

c) 完整填写的投保申请书需与投保单位的营业执照复印件一同交给本公司，营业执照复印件需加盖公章。/ The completed form must be submitted to the Insurer together with a photocopy of the Certificate of Business Registration. The certificate must be stamped with the official seal of the applicant company.

2 投保单位详细资料 / COMPANY INFORMATION

投保单位名称 / Company name

行业类型 / Type of business

注册地址 / Registered address

统一社会信用代码 / Unified Social Credit Identifier No.

3 联系人详细资料 / CONTACT PERSON DETAILS

授权联系人姓名 / Name of authorised contact person

办公地址 / Office address (若不同于注册地址 / if different from registered address)

手机 / Mobile telephone 国家/地区代码 COUNTRY CODE 区号 AREA CODE

办公电话 / Office telephone 国家/地区代码 COUNTRY CODE 区号 AREA CODE

传真 / Fax 国家/地区代码 COUNTRY CODE 区号 AREA CODE

电子邮件 / Email

团体医疗保险管理人 （如与以上部分的联系人不同） / Group Scheme Manager (if different from authorised contact person indicated above)

职务 / Job title

办公地址 / Office address (若不同于注册地址 / if different from registered address)

手机 / Mobile telephone 国家/地区代码 COUNTRY CODE 区号 AREA CODE

办公电话 / Office telephone 国家/地区代码 COUNTRY CODE 区号 AREA CODE

传真 / Fax 国家/地区代码 COUNTRY CODE 区号 AREA CODE

电子邮件 / Email

4 保单生效日期和付款信息 / CONTRACT START DATE AND PREMIUM PAYMENT

保单生效日期 / Contract start date

请注明您要求的保单生效日期 （年/月/日） / Please indicate the date you require cover from (yyyy/mm/dd): / /

仅当本公司接受您的投保申请并签发保单时，本保险合同才成立。您收到本公司签发的团体保险合同时，才表明本公司已接受了您的投保申请。请注意，您的保险生效日期可能与您要求的保单生效日有所不同，保险生效日期以保险合同显示的起始日期为准。 / Cover is conditional upon acceptance of your application, which is only confirmed when a Group Policy Insurance Contract is issued to you. The start date of your cover may be different from your requested start date. Your cover is valid from the start date shown on your Insurance Contract.

保费 / Premium

请注意，保费只能通过银行转帐以人民币支付。/ Please note that the premium can only be paid in CNY by bank transfer.

所报价的总保费 / Total premium as per quote

(在某些省份，根据监管要求，某些保单或所有保单的保费仅能以年缴方式在保单生效前付清。/ Please note that in some Chinese provinces, the premium of some or all policies will need to be settled in full before the policy can be incepted, according to the Chinese regulations.)

请选择付款频率 / Please select your preferred payment frequency below:

月度 / Monthly ☐ 季度 / Quarterly ☐ 半年度 / Half yearly ☐ 年度 / Annual ☐

请注意，付款频率限制因省份地区而异。分期付款需额外交纳管理附加费：**年度付款为 0%，半年度付款为 3%，季度付款为4%，月度付款为5%。**保费按“四舍五入”精确到“元”为单位，因此请注意，分期付款的附加费百分比可能略高于或低于所注明的比例。/ Please note that payment frequency restrictions may be in place for some Chinese provinces. Please also note that payments are subject to the following administration surcharges: **0% for annual payment, 3% for half yearly payments, 4% for quarterly payments and 5% for monthly payments.** Our premiums are expressed in whole numbers (i.e. without any cents), so payment frequency surcharge percentages may be slightly higher or lower than those stated.

收据（发票） / Invoicing

收据（发票）需发至 / Invoice to be sent to (please choose one option) 经代 / Broker ☐ 投保单位 / Company ☐

收据（发票）需发至 的邮箱地址（必填项；仅限一个） / Email address to which invoice is to be sent: only one email address (mandatory field)

收据（发票）需注明地址 / Address to show on invoice

备注 / Other

5 产品详细资料 / PRODUCT DETAILS

请在下表打勾为每个投保等级选择保险级别。每个投保等级所选择的保险级别将适用于该投保等级所包含的所有人员。/ Please tick the options selected for each subgroup. Each subgroup selection will apply to all insured persons included in the subgroup. 如果没有足够的空间用于填写投保等级，请使用另一张《团体医疗险投保申请书》。/ If there is not sufficient space for all subgroups, please use another copy of this form.

计划 / Type of cover/plan	保险级别 / Cover level	投保等级 / Subgroup name:	投保等级 / Subgroup name:	投保等级 / Subgroup name:	投保等级 / Subgroup name:
核心计划 & 门诊计划 / Core Plan & Out-patient Plan	司南至尊计划 / Compass Plus	☐	☐	☐	☐
	司南卓越计划 / Compass Prime	☐	☐	☐	☐
	司南精英计划 / Compass Select	☐	☐	☐	☐
	司南优选计划 / Compass Care	☐	☐	☐	☐
健康体检计划 / Health and Wellbeing Plan	司南健康体检计划 A / Compass Health and Wellbeing Plan A	☐	☐	☐	☐
	司南健康体检计划 B / Compass Health and Wellbeing Plan B	☐	☐	☐	☐
孕产计划 / Maternity Plan	司南孕产计划 A / Compass Maternity Plan A	☐	☐	☐	☐
	司南孕产计划 B / Compass Maternity Plan B	☐	☐	☐	☐
牙科和眼科计划 / Dental and Optical Plan	司南牙科和眼科计划 A / Compass Dental and Optical Plan A	☐	☐	☐	☐
	司南牙科和眼科计划 B / Compass Dental and Optical Plan B	☐	☐	☐	☐
送返计划 / Repatriation Plan	司南送返计划 / Compass Repatriation Plan	☐	☐	☐	☐
承保地域 / Area of Cover	全球 / Worldwide	☐	☐	☐	☐
	全球 (不包含美国) / Worldwide excl. USA	☐	☐	☐	☐
	大中华 / Greater China	☐	☐	☐	☐
	中国大陆 / Mainland China	☐	☐	☐	☐
在昂贵医院就诊时需支付的共付额 / Provider Co-payment with High cost Providers	0%	☐	☐	☐	☐
	20%	☐	☐	☐	☐
	30%	☐	☐	☐	☐
	100%	☐	☐	☐	☐
非标准计划 / Non-standard Plan		☐	☐	☐	☐
每一投保等级的被保险人人数 / Number of insured persons per sub-group					

投保人数：/ Total number of insured persons: （请留意，被保险人数量及保费总额在保险期间可能会发生变化，详情请参阅保险条款。）/ (The number of insured persons is subject to change during the group contract period. For details, please refer to the terms and conditions in the Group Health Insurance Contract.)

当投保团体的员工人数少于10人时，将需要进行医疗核保。在此情况下，每一位投保的员工都需要填写《个人申请表》。/ Please note that groups with fewer than 10 employees to be covered will be subject to full medical underwriting. In this case, each employee to be covered will be required to complete a Member Application Form.

6 请选择门诊计划的免赔额 / SELECT YOUR OUT-PATIENT PLAN DEDUCTIBLE

请注意，您所选择的免赔额将适用于每位被保险成员每次门诊的费用。此免赔额仅适用于私家医院或诊所的门诊咨询。/ The deductible selected will apply to each policy member, per out-patient consultation. It is only applicable to the out-patient consultations in private hospitals/ clinics.

无免赔额 / No deductible ☐ 200元 / ¥200 ☐ 400元 / ¥400 ☐

7 特别约定 / SPECIAL ARRANGEMENTS AGREED WITH THE INSURER

若适用，须由本公司填写 / To be completed by the Insurer, if applicable

8 核保条件 / UNDERWRITING CONDITIONS

若投保的企业团体属于非核保团体，则保险人将根据团体医疗保险合同条款为所有符合条件的被保险人承保，无需核保。前提条件为投保单位按照团体医疗保险合同条款规定为所有符合条件的被保险人投保。/ In the event your application is successful for Medical History Disregarded cover, the Insurer will accept all Eligible Persons added in accordance with the terms of the Group Health Insurance Contract without medical underwriting. This is subject to the company insuring all Eligible Persons in accordance with the Group Health Insurance Contract.

被保险人无需等待期即可享有保单中规定的保险利益。既往病症及慢性疾病属于团体医疗保险合同条款所涵盖的承保范围。/ There are no waiting periods to qualify for covered benefits. Pre-existing and chronic conditions are covered within the terms of the Group Health Insurance Contract.

投保单位同意告知保险人，任何被认为具有重大风险（即健康状况可导致每保险年度理赔总额超过人民币 400,000 元（肆拾万元））或之前曾被保险人或任何其他保险公司拒保的被保险人。根据适用的数据保护法规规定，投保单位有义务在保单生效日期前以及被保险人在加入保单当日或保险级别更新当日告知保险人上述信息。该告知义务涉及投保单位已知或应知的重大风险。若投保单位无法确定已知风险是否为重大风险，则应向保险人披露该风险。保险人有权在新的保险年度开始时重新计算保费，保费金额将反映保险人对额外风险因素的考量。/ The applicant company agrees to notify the Insurer about any Eligible Persons that are deemed to be a material risk (i.e. health conditions that can lead to total claims over ¥400,000 (Four Hundred Thousand CNY) resulting from that condition per insurance year) or where cover has previously been rejected by the Insurer or any previous insurer. The obligation to notify applies prior to the start date of the policy, at the date the Eligible Person is added to the policy or at the date the level of cover was upgraded, subject to applicable data protection regulations. This duty to notify relates to material risks that the applicant company is aware of or should be aware of. If the applicant company is in doubt as to whether a risk is material, it should disclose it. The Insurer reserves the right to recalculate the premium from the start of the Insurance Year to reflect the additional risk.

您是否知晓在保单开始生效时存在下列任何一项“重大风险”（定义如下）且符合条件的被保险人（员工和/或员工家属）？ / Are you aware of any eligible persons (employees and/or dependants) that are a material risk at the start date of the policy, as defined by our ‘material risk’ definition below ?

重大风险是指严重影响到保费计算的健康状况或症状。这种健康状况包括（但不限于）一种不常发作的重大疾病或多胎妊娠。这种重大疾病曾在过去五年内发作过。重大疾病包括（但不限于）以下内容：/ Material risk is a health condition or occurrence that is sufficiently significant to influence the calculation of the insurance premium. Such a health condition includes (but is not limited to) an infrequent dread disease or a pregnancy with multiple births. A dread disease needs to have occurred within the past 5 years. A dread disease will include, but is not limited to:

- 癌症 / Cancer
- 需要终身靶向药物治疗的罕见疾病 / Rare diseases requiring targeted drug therapy lifelong basis
- 慢性炎症性肠病 / Chronic inflammatory bowel disease
- 自身免疫性疾病 / Autoimmune Diseases
- 艾滋病/人类免疫缺陷病毒 / AIDS/HIV
- 多发性硬化症 / Multiple sclerosis
- 需外科手术治疗的冠状动脉疾病 / Coronary Artery Disease requiring surgery
- 肾衰竭 / Kidney failure
- 需进行主要器官移植的疾病 / Condition requiring major organ transplant
- 血友病/血栓形成倾向 / Haemophilia/Thrombophilia
- 慢性感染(例如乙型和/或丙型肝炎) / Chronic Infections (for example Hepatitis B and/or Hepatitis C)
- 瘫痪/截瘫 / Paralysis / Paraplegia
- 粘液粘稠病 / Mucovicidosis
- 先天性疾病 / Congenital Diseases
- 运动神经元病/脑炎 / Motor Neurone Disease/Encephalitis
- 长期昏迷 / Coma
- 绝症 /（被保险人必须正在忍受一种疾病的折磨并且据专业医师意见很可能因此12个月内死亡）/ Terminal illness (the insured person must be suffering from a condition, which in the opinion of a medical practitioner is highly likely to lead to death within 12 months)

若被保险人患有上述任何一种疾病，请投保单位向保险人提供有关该被保险人相关医疗情况的全部已知信息。/ If yes, please provide us with full details of information known to the company relating to the medical condition of the eligible person.

9 保单文件 / DOCUMENTATION

语言/ Language

请注明您希望收到哪种语言的保单文件和信件 / Please specify in which language you prefer to receive the policy documents and any communication:

中文 / Chinese ☐ 英文 / English ☐

交付方式 / Delivery

请注明被保险人的保单文件送交地址 / Please specify where the policy documentation for each insured person should be sent:

经代公司 / Broker ☐ 投保单位 / Company ☐

文件格式 / Format

您希望向被保险人提供哪种格式的保单文件？ / In which format would you like the policy documentation to be provided to the insured persons?

电子文档 / Soft copy ☐ 纸质文档 / Printed copy ☐

10 在线服务 / ONLINE SERVICES

所有被保险人均可使用在线服务 / Please note that the Online Services facility is available to all insured members.
请注明以下团体是否需要使用在线服务(只读访问)？ / Is the Online Services (read only access) facility required for?
团体医疗保险管理人/ Group Scheme Manager ☐ 经代管理人/ Contact person at broker company ☐

11 报告 / REPORTS

自动报告 / Automated Reports

（每半个月发送一次，于每月7号和20号发送，数据统计至前一个月的月底）请留意，自动报告的语言仅可为英文 / (Run on the 7th for monthly reports and on the 20th for fortnightly reports – all reports run to the end of previous month of issue date.)

Please note that automated reports are only available in English.

理赔报告（仅限经验费率团体） / Claims Reports (for experience rated groups only):

理赔报告发送至 / Claims Reports to be sent to:

收件人电子邮件地址 / Recipient's email address:

请选择您希望收到理赔报告的频率 / Please select the frequency in which you want to receive your Claim Reports:

月度 / Monthly ☐ 季度 / Quarterly ☐ 半年度 / Half yearly ☐ 年度 / Yearly ☐

如果团险计划包含多个投保等级，请说明发出的报告需划分为 / If more than one subgroup exists within the scheme, please indicate whether the reports should be issued per:

投保等级 / Sub-group ☐ 整个投保单位 / Entire business group ☐

被保险人名单（适用所有团体） / Membership Lists (for all groups)

被保险人名单发送至 / Membership Lists to be sent to:

收件人电子邮件地址 / Recipient's email address:

请选择您希望接收被保险人名单的频率 / Please select the frequency in which you want to receive your Membership Lists:

每两周 / Fortnightly ☐ 每月 / Monthly ☐ 每两月 / Two-monthly ☐ 每季度 / Quarterly ☐

每半年 / Half-yearly ☐ 每年 / Yearly ☐

如您有其他特殊要求，请联系本公司以商讨服务内容选项 / If you wish to apply specifics settings to each of your sub-groups, please contact the Insurer to discuss the options available to you.

12 投保单位声明 / DECLARATION

请注意，您签发本投保申请书将视为您理解并作出如下承诺： / Please read the following declarations carefully and only sign below if you understand and accept them:

a) 在决定投保前，经保险人提示、解释和明确说明，本单位已仔细阅读了保险条款，并已充分理解保险条款的全部内容，特别是与保险责任、免除保险责任、合同解除有关的关键条款。本单位确认对保险条款及投保须知的全部内容均已充分了解并同意遵守。 / By signing below, the applicant company acknowledges that, prior to completing this form, they have been provided with the Group Health Insurance Contract, including the terms and conditions of this policy: they have read and understood all the clauses, especially those related to benefits definitions, exclusions and policy cancellation. They agree to abide by the terms and conditions of this policy.

b) 仅保险人正式书面签发的保单、批单才具有保险合同的法律效力，其他任何口头及书面承诺均不具有效力，保险人无需负责。 / Only the policy documentation and any official endorsements issued by the Insurer are binding for the purposes of the insurance cover: any other oral and/or written statements are invalid and the Insurer will not be responsible for them.

c) 本单位在投保申请书、被保险人清单中所填的各项内容均属实，且均已经被保险人或其法定监护人同意。本单位保证未隐瞒、虚假陈述或错误说明任何重要事实（例如，有可能影响保险人评估风险或决定是否承保的事实，若不了解某项事实是否为重要事实，则已向保险人报告）。本单位理解本投保申请书应构成投保单位与保险公司之间的合同基础，任何错误、不正确或误导的声明都可能导致该保险合同无效或失效。 / All details provided by the applicant company in this form are truthful and have been given with the consent of the insured person or their legal guardian. The applicant company declares that they have not suppressed, misrepresented or misstated any material facts (i.e. facts likely to influence the Insurer's assessment and acceptance of this application. If in doubt as to whether a fact or information is material, then it must be disclosed). The applicant company understands that this application shall be the basis of the contract between them and the Insurer and that any false, incorrect or misleading statement may render this insurance contract null and void.

d) 通过签章，本单位向保险人保证，本单位有权代表所有被保险人处理其提供给保险人的所有个人信息，本单位已获得被保险人的授权披露这些个人信息用于管理保险合同。本单位同意并有权代表所有被保险人同意保险人、保险人指定的第三方服务提供商或保险人的代表为了保险合同的目的而处理、披露、使用和保留被保险人的信息。 / By signing this form, the applicant company warrants and represents to the Insurer that they have the authority to act on behalf of all insured persons in respect of all personal information provided to the Insurer; they have the authority of the insured persons to disclose this personal information for the purposes of this policy administration; they confirm that the insured persons consent to the processing, disclosure, use and retention by the Insurer, their appointed third-party service providers or their representatives, of the insured persons' information on their behalf.

e) 本单位有权代表所有被保险人同意保险人为本保险的目的收集被保险人的个人资料(该资料不论是从本投保单上或其他地方所获取)并授权可由保险人或任何与保险人有关的机构（监管机构或行业协会保险信息平台）或其他人士(不论在中国或海外地方)持有、转告、及用于处理及审核此投保单或其他保险事宜，提供与该保险有关之服务，及与被保险人联络的用途。/ The applicant company on behalf of the insured persons agree that the insured persons' personal information collected or held by the insurer (contained in this Application Form or otherwise obtained) may be held, used and disclosed by the insurer to organizations (Regulatory Bodies or Insurance Associations) or individuals associated with the insurer (within or outside China) for the purposes of (i) processing this application and other insurance related matters, (ii) providing insurance services and (iii) communicating with the insured persons.

f) 保险合同的生效日以团体保险单上所载的日期为准。 / The effective period of the insurance contract will be specified on the Group Policy Details.

g) 本单位的联系人在保单生效期内有权代表本单位全权办理保险合同的各项变更事宜。所有变更申请资料可通过此申请表内列明的电子邮箱发送给保险人，本单位将通过联系人的上述邮箱接收各项保全变更的确认，通过上述电子邮箱发出和接受的文件，联系人认可其效力并承担相应的法律责任。在保险期间内联系人或电子邮箱发生变动，本单位需及时重新书面联系保险人，否则原联系人及其邮箱地址对保险人继续有效，由此产生的一切后果均由联系人承担。/ The Company hereby authorises the above named authorised contact person(s) to provide the Insurer with any insurance scheme information (including membership changes) via e-mail. The above named authorised contact person(s) will have full legal authority to represent the Insured Company during insurance year. All scheme information will be submitted to the Insurer by the authorised contact person(s) from the e-mail address stated in this form. The Insurer will send confirmation of membership changes to the authorised contact person(s) at the same e-mail address. To change the authorised contact person/ email address, the Company will be required to contact the Insurer in writing. If the Insurer does not receive notification of a change to the authorised contact person, the Company will continue to be contractually bound by the authorised contact person(s) appointed above.

h) 通过签章，本单位确认，保险合同续保时，在收到保险人提供的续保条款和续保费率后，本单位会在一个月内以书面形式通知保险人是否接受续保条款和保费价格， 保持缄默或按续保费率支付保费表示本单位接受续保（包括保险人对保险条款的任何变更以及对保险费率的调整），且以保险人获知的最新的被保险人信息、保险计 划接受保险人的保费付款通知。/ By signing this form, the applicant company understands that, should the contract be formed and where the Insurer offers the renewal of the contract, the Insurer will issue to the applicant company the renewal terms and conditions (including any changes) and the revised renewal premium. The applicant company will be required to reply within one month in writing about their acceptance or refusal of the revised renewal conditions and premium. Silence or payment of the renewal premium will be taken as an acceptance of the revised renewal terms. The applicant company will be liable to pay the premium calculated in accordance with the latest membership details available to the Insurer.

投保单位负责人签字 / On behalf of the applicant company (signature)

经代公司签署 / Broker's signature

投保单位盖章 / Applicant company's stamp

日期（年/月/日） / Date (yyyy/mm/dd) / /

日期（年/月/日） / Date (yyyy/mm/dd) / /

仅限办公人员填写 / FOR OFFICE USE ONLY:

经代公司信息 / Broker Details

经代公司名称 / Broker company name

经代公司号码 / Broker ID

经代公司联系人 / Contact person at broker company

办公地址 / Office address

电话 / Telephone

国家/地区代码 COUNTRY CODE 区号 AREA CODE

传真 / Fax

国家/地区代码 COUNTRY CODE 区号 AREA CODE

邮箱 / Email

佣金% / Commission %

京东安联财产保险有限公司的综合偿付能力充足率达到监管要求，且最近季度风险综合评级（分类监管）结果为A类。详情可登录 https://www.jdallianz.com/zh/public-info/public-info.html#power 查询。/ The solvency ratio of Allianz Jingdong General Insurance Company Ltd is currently higher than regulator's requirement. The most recent integrated risk rating is level A. More information is available on our website https://www.jdallianz.com/zh/public-info/public-info.html#power.

京东安联财产保险有限公司是本保险单的保险人并提供中国大陆境内的保单服务。京东安联财产保险有限公司注册于中国并受中国银行保险监督管理委员会监管。注册地址：广东省广州市天河区珠江西路5号广州国际金融中心主塔写字楼第34层01-05、11、12单元，统一社会信用代码：914400005517258765。/ Allianz Jingdong 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 Banking and Insurance Regulatory Commission. Registered Office: Unit 01-05, 11 & 12, 34th Floor, Main Tower, Guangzhou International Finance Center, 5 Zhujiang Xilu, Tianhe District, Guangzhou, Guangdong, P.R. China. Registered No.: 914400005517258765.

AWP Health & Life SA 是一家注册于法国的有限责任公司并受法国保险法规监管，其爱尔兰分公司受京东安联财产保险有限公司委托代为管理中国大陆境外的保单服务。法国注册号：No. 401 154 679 RCS Bobigny(博比尼)。爱尔兰分公司在爱尔兰登记注册，注册号：907619。地址：15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12 (都柏林), Ireland (爱尔兰)。Allianz Care和Allianz Partners是AWP Health & Life SA的注册贸易名称。/ AWP Health & Life SA, acting through its Irish Branch, is engaged by the insurer for the administration of the insurance policy outside mainland China. AWP Health & Life SA is a limited company governed by the French Insurance Code. Registered in France: No. 401 154 679 RCS Bobigny. Irish Branch registered in the Irish Companies Registration Office, registered No.: 907619, address: 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. Allianz Care and Allianz Partners are a registered business name of AWP Health & Life SA.