MSH CHINA
Health Insurance Services & Solutions

中国大地保险
China Continent Insurance

2024
精选个人
全球医疗保险 投保单

ADVANCED INDIVIDUAL HEALTH PLAN PROPOSAL

第一部分：投保人及被保险人信息　Section 1. Application Details

投保人 (在投保人和主被保险人一致的情况下，可直接从主被保险人部分开始填写)
Applicant (If the Applicant is the same as the Primary Insured, please go directly to the Primary Insured Part.)

投保人名称 Applicant Name:

电话Tel:

永久地址及邮编 Permanent Address & Postcode:

邮寄地址及邮编 Mailing Address & Postcode:

电邮Email:

主被保险人 Primary Insured

姓 Last Name:	名 First Name:
性别 Male or Female:	生日 (月/日/年) Date of Birth (MM/DD/YYYY):
身高 Height (cm):	体重 Weight (kg):
国籍 Nationality:	身份证或护照号码 ID or Passport No.:
职业 Occupation :	公司 Employer:
电话Telephone:	电子邮件Email:

居住地址 Residential Address:

居住城市 City of Residence: 邮编Zip:

推荐的邮寄地址 Where You Would Like to Receive Your Insurance Card :

紧急情况联系人 Emergency Contact Person :

电话 Telephone : 电子邮件 Email :

是否拥有公费医疗、基本医疗保险或其他费用补偿医疗保险?
Do you have public medical care, basic medical insurance or other cost-compensation medical insurance? ☐ 是 YES ☐ 否 NO

附属被保险人 Dependents

	1	2	3	4
姓 Last Name:				
名 First Name:				
性别 Male or Female				
生日 (月/日/年) Date of Birth (MM/DD/YYYY):				
身高 Height (cm):				
体重 Weight (kg):				
国籍 Nationality:				
身份证或护照号码 ID or Passport No.:				
居住城市 City of Residence:				
公费医疗、基本医疗保险或其他费用补偿医疗保险 Public medical care, basic medical insurance，cost-compensation medical insurance?	☐ 是 YES ☐ 否 NO	☐ 是 YES ☐ 否 NO	☐ 是 YES ☐ 否 NO	☐ 是 YES ☐ 否 NO

第二部分：投保保障 Section 2. Coverage

预计起保日期 Proposed Effective Date

(月/日/年 MM/DD/YYYY)

注：请尽量预留至少5个工作日（由递交申请表日起计）用于入保及付款。保险费一般应该在保险生效日期之前交纳。
Note: Please leave at least 5 working days (from the date submitting the application form) for enrollment and payment. Premium should be received before policy effective date.

保险方案选项 Plan Selected 同一保单内被保险人需同时选择/不选择相同的补充健享包 The Primary insured and Dependents must simultaneously opt in/out of the same Optional Supplementary Wellness Benefit

保险方案选择 Plan Selected		☐ 大中华增强保障 Greater China Plus Plan	☐ 国际增强保障 International Plus Plan	☐ 全球保障 Worldwide Plan
医院涵盖范围（全球保障不适用） Hospital Coverage (N/A for Worldwide Plan)		☐ 选项一 Option 1 公立医院及私立医院，不含昂贵医院 Public Hospitals and Private Clinics/ Hospitals, excluding High Cost Providers	☐ 选项二 Option 2 公立医院及私立医院，含昂贵医院 Public Hospitals and Private Clinics/ Hospitals, Including High Cost Providers	
成人 Adults	主被保险人 Primary Insured	☐ 仅住院 Inpatient Only ☐ 住院+门诊 Inpatient + Outpatient	免赔额选择 (适用于单独住院计划) Deductible Options (Available for Inpatient Only Plan) ☐ RMB 0 ☐ RMB 30,000 ☐ RMB 12,000 ☐ RMB 50,000	
		可选补充健享包 (限住院+门诊) Optional Supplementary Wellness Benefit (IP+OP only)	☐ 不选择 N/A	☐ RMB 2,000 ☐ RMB 5,000
	附属被保险人1 Dependents 1	☐ 仅住院 Inpatient Only ☐ 住院+门诊 Inpatient + Outpatient	免赔额选择 (适用于单独住院计划) Deductible Options (Available for Inpatient Only Plan) ☐ RMB 0 ☐ RMB 30,000 ☐ RMB 12,000 ☐ RMB 50,000	
		可选补充健享包 (限住院+门诊) Optional Supplementary Wellness Benefit (IP+OP only)	☐ 不选择 N/A	☐ RMB 2,000 ☐ RMB 5,000
子女 Children	附属被保险人2 Dependents 2	☐ 仅住院 Inpatient Only ☐ 住院+门诊 Inpatient + Outpatient	免赔额选择 (适用于单独住院计划) Deductible Options (Available for Inpatient Only Plan) ☐ RMB 0 ☐ RMB 30,000 ☐ RMB 12,000 ☐ RMB 50,000	
		可选补充健享包 (限住院+门诊) Optional Supplementary Wellness Benefit (IP+OP only)	☐ 不选择 N/A	☐ RMB 2,000 ☐ RMB 5,000
	附属被保险人3 Dependents 3	☐ 仅住院 Inpatient Only ☐ 住院+门诊 Inpatient + Outpatient	免赔额选择 (适用于单独住院计划) Deductible Options (Available for Inpatient Only Plan) ☐ RMB 0 ☐ RMB 30,000 ☐ RMB 12,000 ☐ RMB 50,000	
		可选补充健享包 (限住院+门诊) Optional Supplementary Wellness Benefit (IP+OP only)	☐ 不选择 N/A	☐ RMB 2,000 ☐ RMB 5,000
	附属被保险人4 Dependents 4	☐ 仅住院 Inpatient Only ☐ 住院+门诊 Inpatient + Outpatient	免赔额选择 (适用于单独住院计划) Deductible Options (Available for Inpatient Only Plan) ☐ RMB 0 ☐ RMB 30,000 ☐ RMB 12,000 ☐ RMB 50,000	
		可选补充健享包 (限住院+门诊) Optional Supplementary Wellness Benefit (IP+OP only)	☐ 不选择 N/A	☐ RMB 2,000 ☐ RMB 5,000

其他需求： Any other conditions, please specify below :

投保类型 Application Type

☐ 单人 Single ☐ 夫妇 Couple ☐ 亲子 Single Parent Family ☐ 家庭 Family

付款人 Payer

☐ 开具个人抬头发票 Personal Name Titled Tax Invoice (以主被保险人姓名开具发票 Fapiao is issued under the primary insured's name.)
若未作选择，将默认为个人付款 Personal payment is the default option if not specified

☐ 开具公司抬头发票 Company Name Titled Tax Invoice (以主被保险人公司中文名开具发票 Fapiao is issued under the primary insured's company Chinese name.)

公司中文名称 Company Chinese Name:

公司纳税人识别号 Company Taxation Registration No.:

争议解决方案 Solutions to Dispute

☐ 仲裁 Arbitration 提交 Present to 仲裁

☐ 诉讼 Litigation 交有管辖权的人民法院裁决 Present to the court with jurisdiction

*若不选择，默认诉讼解决方式。 If you don’ t choose, the default choice is litigation.

第三部分：健康调查问卷　Section 3. Medical Questionnaire

请就主被保险人及其每一附属被保险人的健康状况回答下列问题。投保单上所有勾选事项请以"√"表示。若答案为“是”请详细说明。
Please answer YES or NO to each of the following questions for the primary insured and each of his/her dependents if any. For any of your options please tick"√". For each YES answer, please explain and provide details.

1. 曾住过院或做过手术? Been admitted to a hospital/other medical facility or had surgery?	☐	YES是	☐	No否
2. 曾伤残过或治疗费超过人民币40,000元? Been disabled and/or incurred medical costs exceeding RMB 40,000?	☐	YES是	☐	No否
3. 体检时被告知有任何异常? Been told that there was any abnormity during checkup?	☐	YES是	☐	No否
4. 曾因病或遭受意外伤害而休病假30日或以上? Suffered from a disease or an accident entailing 30 days or more sick leave and/or medical treatment?	☐	YES是	☐	No否
5. 在一年内有入院或手术安排? Scheduled surgery/inpatient treatment in one year?	☐	YES是	☐	No否
6. 有不适症状、曾经被诊断有或治疗过以下情况: Had any health problems or complaints, been diagnosed with, or had treatment for any of the following:				
A. 慢性咳嗽，咯痰，咯血，哮喘，呼吸困难，支气管扩张，气胸，肺气肿，结核，胸膜炎，慢性支气管炎或其他呼吸系统疾病? Chronic cough, expectoration, hemoptysis, asthma, difficulty breathing, bronchiectasis, pneumothorax, emphysema, tuberculosis, pleurisy, chronic bronchitis, or other diseases of the respiratory system?	☐	YES是	☐	No否
B. 腰痛，尿频，尿急，尿痛，排尿困难，血尿，蛋白尿，尿量异常，夜尿增多，肾或尿路结石，肾炎，肾病，肾囊肿，肾积水或其他泌尿系统疾病? Back pain, frequent urination, urgency of urination, pain in urination, difficulty urinating, blood or protein in the urine, abnormal amount of urine, nocturia, kidney and urinary tract stone, nephritis, nephropathy, renal cyst, hydronephrosis, or other urinary system problems?	☐	YES是	☐	No否
C. 返酸，嗳气，恶心，腹胀，腹痛，便秘，腹泻，呕血，黑便，便血，黄疸，吞咽困难，溃疡，肠炎，胃病，疝气，直肠疾病，乙肝病毒携带，肝脏疾病，胆囊疾病，胰腺疾病或其他消化系统疾病? Belch, nausea, abdominal distention, abdominal pain, constipation, diarrhea, hematemesis, melena, hematochezia, jaundice, difficulty swallowing, ulcer, colitis, stomach problems, hernia, rectal problems, HBV Carrier, liver disorders, gall bladder disorder, pancreas problems or other digestive system problems?	☐	YES是	☐	No否
D. 心悸，活动后气促，咯血，静脉曲张，胸部不适或胸闷，晕厥，风湿热或心脏杂音，心律不齐，心肌炎，心血管疾病，心肌梗死，中风，动脉瘤，冠心病，高血压，高血脂，或其他循环系统疾病? Palpitation, tachypnea after exercise, hemoptysis, varicose veins extremity, chest discomfort or pressure, syncope, rheumatic fever or Heart murmur, arrhythmia, myocarditis, cardiovascular disease, myocardial infarction, stroke, aneurysm, coronary heart disease , hypertension, hyperlipaemia, or other circulatory system disorder?	☐	YES是	☐	No否
E. 头昏，牙龈出血，鼻出血，皮下出血，紫癜，骨痛，贫血或其他血液系统疾病? Dizziness, nosebleed, subcutaneous, hemorrhage, purpura, pain in bone, anemia, or other blood system disorders?	☐	YES是	☐	No否
F. 关节炎，痛风，腰背痛，颈椎病，腰椎病，肌肉萎缩，神经损害或其他肌肉骨骼 / 关节疾病? Arthritis, gout, neck pain, back and lumbar pain, cervical vertebral disease, lumbar vertebral disease, myophagism, nervous lesion or musculoskeletal/joint problems?	☐	YES是	☐	No否

G.多汗，多尿，双手震颤，肥胖，色素沉着，闭经，糖尿病，甲状腺疾病，或其他代谢和内分泌系统疾病？ Hyperhidrosis, polyuria, tremor on hands, obesity, pigmentation, amenorrhea, diabetes, thyroid diseases, or other metabolism and endocrine system problems?	☐	YES是	☐	No否
H. 头昏，眩晕，晕厥，记忆力减退，视力障碍，意识障碍，震颤，抽搐，惊厥，瘫痪，感觉异常，癫痫，失去知觉或其他神经系统疾病？ Dizziness, vertigo, syncope, hypomnesis, disturbance of vision, disturbance of consciousness, tremor, convulsions, seizure, paralysis, sensory abnormity, epilepsy, loss of consciousness or other nerve system disorder?	☐	YES是	☐	No否
I. 前列腺疾病，乳腺痛，乳腺炎，月经不调，月经过多，子宫内膜异位症，子宫异常增大，卵巢囊肿， 不孕不育，或其他男 / 女性生殖系统疾病？ Prostate disorder, mastalgia, mastitis, Irregular menstruation, menorrhagia, endometriosis, abnormal growth in the uterus, ovarian cyst, Infertility, or other diseases of the male/female reproductive organs, including venereal diseases?	☐	YES是	☐	No否
J. 癌症，瘤或肿块，结节，息肉，囊肿，腺体、淋巴结或器官增生肿大，皮肤疾病或色素沉着，乳房异常增生或其他相关的疾病？ Cancer, tumor or mass, nodules, polyps, cysts, enlarged glands, lymph nodes or organ, disorders of the skin or pigmentation, abnormal growth in the breasts or any related conditions?	☐	YES是	☐	No否
K. HIV病毒感染，艾滋病，艾滋相关综合征或其他免疫系统疾病，传染病或性病？ HIV infection, AIDS, AIDS-related complex or other immune deficiency disorders, infection problems or venereal diseases?	☐	YES是	☐	No否
L. 酗酒，吸毒，药物滥用，精神/神经、行为、情感或饮食障碍？ Alcohol or substance abuse, mental/nervous, behavioral, emotional, or eating disorders?	☐	YES是	☐	No否
M. 白内障、青光眼或其他眼疾患；听力损失；任何耳鼻喉疾患？ Cataracts; glaucoma; or any eye disorder; hearing loss; or any ear nose, or throat disorder?	☐	YES是	☐	No否
N. 伤残性疾病，身体缺陷，生长发育异常，智力低下，遭受意外伤害影响、先天性疾病，遗传性疾病，基因缺陷，家族病史？ Disabling illness, physical defect, heteroplasia, amentia, suffers from the consequences of accident, Congenital disease, hereditary disease, genetic defect, any family medical history?	☐	YES是	☐	No否
O. 女性主/附属被保险人适用： Female primary/dependent insured are applied: a. 现在怀孕了吗？ Now pregnant? b. 是否有怀孕并发症？如有，请提供详细病历资料。 Have any complications of pregnancy? If yes, please present medical record. c. 预产期： Expected date of delivery:	☐	YES是	☐	No否
P. 除了以上情况主被保险人或其附属被保险人： Other than previously stated: a. 每天抽烟超过15支或以任何方式食用烟草？ Smoke more than 15 cigarettes per day or use tobacco in any form? b. 在过去5年中，一年内体重增加或减少超过12公斤或25磅？ Within the past 5 years, gained or lost more than 12kg or 25lbs during 12 months?	☐	YES是	☐	No否
c. 其他的A-O中未列出的症状/疾病（无论是否已向医生或其它医疗保健人士咨询、就诊）？如果有，在下面的表格中请详细描述。 Any other medical condition that has not been disclosed above A-O, regardless of whether a doctor or other health care professional has been consulted? If so, describe in detail below.	☐	YES是	☐	No否

对于回答“是”的项目，请在下面详细说明（可附页）。必要时，请提供医疗报告。
Please explain any YES answers below (Attach additional pages if necessary). Medical report may be required if necessary.

问题号 Q. No.	姓名 Name of the insured	诊断、症状或病情 Diagnosis, symptoms or medical conditions	初次发生时间 Time of first occurrence	治疗详情， 包括治疗日期、用药等 What treatment did you receive and when? (Please include dates and any medication prescribed)	现在情况 （如：痊愈，观察，仍在治疗，还在反复发作中等。如果已经痊愈，请告知痊愈时间。） Current Status (e.g. complete recovery, still under review, ongoing, recurrent or likely to recur? If it is complete recovery, please inform the time.)

声明DECLARATION

1. 我声明我所填写的内容是真实的，也是我所能提供的全部信息。若此表是他人代为填写的，我确认所填写的内容是真实的。我明白未真实、完全填写或故意隐瞒与此保险相关的事实会导致保险失效；如果我违背本声明，保险人有权终止保险合同且不退还保险费。
I declare that I have answered all the questions truthfully and to the best of my knowledge. If this form has been completed on my behalf, I agree to the truthfulness of the responses given. I understand that any incorrect or incomplete answer or the concealment of any facts relevant to this insurance may invalidate this policy. I also understand that the insurer shall be entitled to retain all premiums paid during the policy year by virtue of a breach of this declaration.
2. 在此声明后至保险正式生效日之前，如上述声明内容发生改变，我应及时通知保险人，保险人有权进行重新评估。
I am also aware that I have to notify the insurer of any fact material to this insurance, which arises between the date of this declaration and the inception of this policy.
3. 我谨此授权凡知晓或拥有任何有关我健康、医疗及其他相关信息的任何医生、医院、保险公司、其它机构或人士，均可将此类信息提供给你公司，此授权书的影印本也同样有效。
I hereby grant my authorization for any doctors, hospitals, insurance companies, other institutes or persons that know or own any of my health, medical and the other relevant information to provide such information to your company. Copy of this authorization letter is also valid.
4. 你公司已对投保险种的各项保险条款内容履行了说明义务，并对保险责任、保险期间、责任免除条款、免赔额、免赔率、比例赔付、退保条款、等待期条款、理赔条款等履行了明确说明义务，我已经完整阅读本投保单第一至第五页并且均已理解，并同意遵守。我明白且接受：对于任何被保险人，未告知或未经保险人核保同意的既往症不属于保险责任。
Your company has fulfilled the duty of explaining the product provisions, especially the policy benefits, period of cover, exclusions, deductible, deductible rate, proportion of payment, policy cancellation, waiting period, and claims etc. I have read the application form entirely from page 1 to page 5 and understood the above contents and hereby consent to comply. I understand and accept: For all Insured, no benefit will be payable to any pre-existing condition which is not disclosed or not approved by the Insurer.

投保人及主被保险人签名
Signatures of Applicant and Primary Insured
日期（月/日/年）
Date (MM/DD/YYYY)

INDIVIDUAL PLAN

Application Form

MSH CHINA
Health Insurance Services & Solutions

尊敬的客户：

1. 为使您充分了解投保内容并维护您的权益，投保前请向业务代表索要保险条款，并要求业务代表详细解释保险条款，特别是保险责任、责任免除等重要内容。请在业务代表已解释保险条款，您已仔细阅读本保险相关内容和条款，确认已充分理解保险责任、责任免除、如实告知、合同解除等重要事项后做出投保决定。
2. 投保单及其它保险人认为有必要的资料（以下简称“投保资料”）是本公司签发保险单的依据，将成为保险合同的重要组成部分，对于本公司提出的各项询问，投保人、被保险人须如实告知，本公司承诺对投保资料内容保密。
3. 本投保单须由投保人亲笔签名确认,不得以任何形式委托他人代签。
4. 若您已填写投保资料并签名，将视为您已充分理解保险条款并同意遵守。
5. 整个保险年度内，您本人和附属被保险人（若有，下同）必须在中国大陆、香港、澳门或台湾地区居住合计达到保险期间的三分之二或以上时间。如果不能或不确定，请于投保前告知您的经纪人/代理人/销售和保险人。
6. 健康调查问卷是为了评估您本人和附属被保险人的身体状况以确定相应的保险保障，请如实填写。除非经保险人核保同意，保险人对既往症不承担任何保险责任。既往症：指在保险人对其保险责任生效前被保险人已就此接受诊断、医学咨询或者治疗，或者服用药物，或者显现症状的疾病或者损伤。请注意，您在第三部分“健康调查问卷”披露的信息将用于评估您连续投保的保险保障。
7. 收到保险费后，保险人将向您及附属被保险人签发保险卡。该保险卡将作为在网络医疗机构接受治疗时享受直接付费服务（免现金支付）的凭证，我们将与医疗机构结算相关费用。若需开通直接付费服务，请您完整填写客户确认函。对于您及您的附属被保险人在网络医疗机构接受治疗而发生的、不属于保险责任范围内、应由您及您的附属被保险人承担但网络医疗机构未向您及您的附属被保险人收取的医疗费用，请您在保险人或其代表通知您之日起30日内向保险人归还相应费用，否则，保险人将有权取消您及附属被保险人在网络医疗机构享受直接付费服务，甚至取消保险合同且不退还保险费。

Dear member,

1. In order for you to fully understand the insurance applied for and so as to protect your rights and interests, please ask sales representative/broker for the policy wording and detailed explanations of the policy wording, particularly in terms of important contents such as benefits and exclusions before apply. Please make your application decision only when sales representative has explained the policy wording; you have carefully read relevant insurance contents and policy wording; and you have fully understood important issues like benefits, exclusions, honest disclosure and contract cancellation.
2. The Application Form, and other files deemed necessary by the Insurer (hereinafter “application files”) are basis for the Insurer to issue the Insurance Contract and will be an important part of the Insurance Contract. For all inquires of the Insurer, the Policyholder and the Insured should disclose honestly, the Insurer guarantee to keep confidential of the application files.
3. The application form may only be signed by the policyholder. No other party or person may sign on behalf of the policyholder.
4. If you fill in and sign the application files, it should be regard that you fully understand the policy wording and agree to abide by it.
5. You and your dependents (if any) must reside within Mainland China, Hong Kong, Macao and Taiwan for at least two thirds of the policy year. Please inform brokers/agency/sales representative and the Insurer if you are unsure not able to meet residential requirement.
6. The purpose of the Medical Questionnaire is to evaluate the health conditions for you and your dependents (if any) and to determine coverage, please answer the questions as truthfully and thoroughly as possible. Pre-existing conditions, if any, will not be covered unless approved by the insurer. For the purpose of your health insurance, Pre-existing conditions are defined as “any Illness or Injury, physical or mental condition, for which an Insured Person received any diagnosis, medical advice or treatment, or had taken any prescribed drug, or where distinct symptoms were evident prior to the effective date.” Please pay attention the information you disclosed in Section 3 Medical Questionnaire will be applied to evaluate your coverage for the continuous policy year.
7. Upon receiving your insurance premium, you and your dependents if any will be given an insurance card. The insurance card can be used at our “direct billing providers” where the provider sends claims to us for direct settlement. If you wish to access to the direct billing, please complete Confirmation Letter. However, if a direct billing provider is used, for any expenses not eligible to be covered by the policy and not collected by the provider, you should pay the corresponding expenses to the Company within 30 days from the day of notification by the Company or its behalf. Otherwise, the Company has the right to cancel direct billing services or even cancel the contract with no refund of premium.

MSH CHINA
Health Insurance Services & Solutions

尊敬的客户：

8. 我声明我已充分阅读、了解并同意《中国大地财产保险股份有限公司个人全球医疗保险（B款，2024版）条款》
9. 我声明我已充分阅读、了解并同意《中国大地财产保险股份有限公司个人全球医疗保险-精选个人全球医疗保险计划书（含保费费率表》
10. 为保证后续理赔服务的畅通，本投保人人代表被保险人同意大地保险（指中国大地保险股份有限公司及其各级分支机构）及其因服务必要而委托的境内外第三方基于为被保险人提供服务的用途，可以收集、整理、保存、加工、提供和使用本人提供的及享受大地保险服务而产生的信息（包括但不限于本单证签署之前提供和产生的），但法律禁止的除外。大地保险及其委托的第三方对上述信息负有保密义务。

Dear member,

8. I hereby acknowledge and agree the reality and validity of CCIC Individual Health Insurance Policy（Version B, 2024).
9. I hereby acknowledge and agree the reality and validity of CCIC Individual Health Insurance - ADVB Individual Health Plan Proposal (including ADVB Individual Annual Premium Table).
10. The policyholder agrees that the insurer and the related branches point the third party for the purpose of providing quality service to insure afterwards claim experience. The third party can, in a legislative way, collect, compile, save and use the information of the policyholder, the primary insured and their dependents, as a result of using the insurer’ s service (including but not limited the information incurred before signing this document). The insurer and the third party have the obligation to maintaining confidentiality.

我已阅读、了解并同意本页及投保单第一、二、三部分内容。
I hereby acknowledge that I have read, understand and agree to the terms and conditions stated above in this page and part 1, part 2 and part 3 of the Application Form.

投保人签名
Applicant Signature
日期（月/日/年）
Date (MM/DD/YYYY)

MSH CHINA
Health Insurance Services & Solutions

客户确认函
Confirmation Letter

我（全名）_____，作为万欣和(上海)企业服务有限公司（ “万欣和” ）服务的保险计划下主被保险人已阅读并确认如下内容：
I (full name)_____, as the primary insured enrolled under the Plan served by MSH China Enterprise Services Co., Ltd. (MSH China), have read and confirm the below content:

1. 我，及万欣和服务的保险计划下的附属被保险人（如有）已知晓并接受保险中与除外责任及既往症福利相关的条款。
I, and the insured dependents(if any) enrolled under the Plan served by MSH China , hereby understand and accept the clauses in policy wording relating to exclusions and pre-existing conditions.

2. 我/我们，在此承诺在收到万欣和通知后起30 日内，将承担所有我/我们在保险期间内因享受万欣和提供的直接付费服务而产生的应由我/我们承担但并未支付的费用。此类情况包括但不限于：
I/ We agree that I/ we will be fully responsible for reimbursement to MSH China within 30 days upon receiving notice of all treatment costs which should be paid by me/us but actually did not when I/we receive direct billing service provided by MSH China. Reasons that may cause the above circumstance include, but are not limited to:
（1）我/我们接受此保险不包含的治疗。
The treatment is not covered by the Plan.
（2）我/我们就诊时，没有向直付医院支付的相应自付额。
The co-payment that was not collected by the direct billing provider at the time of the visit.
（3）我/我们接受与保前疾病/既往症相关的治疗不在保险责任范围内。
The treatment is related to a pre-existing condition that is not covered by the Plan.

3. 我/我们理解并接受：如果我/我们在收到万欣和通知后三十日内仍未向万欣和支付上述不属于保险责任范围内的医疗费用，保险人有权立即取消保险合同并不退还保险费。并且，万欣和保留追回上述欠款的权利。本承诺书从签署之日起生效，至保险到期之日终止(如果保险续保，保险到期日指续保到期之日)。
I/ We understand and accept that if I/ we fail to return the uncovered expenses to MSH China within 30 days, MSH China has the right to cancel the policy immediately and there will be not any premium refund. Furthermore, MSH China reserves the right to collect the uncovered expenses. The Guarantee Letter shall take effect from date of the signing and expire on the termination date of the Plan (if the Plan is renewed, the termination date of Plan refers to the termination date of renewed Plan).

投保人及主被保险人签字:
Signatures of Applicant and Primary Insured:
日期 (月/日/年) :
Date (MM/DD/YYYY) :

材料清单
Checklist

*请完整填写并签署所有表格并将原件寄至业务代表或万欣和（上海）企业服务有限公司以完成入保工作。
Please complete and sign Form(s) and return to sales representative/broker or MSH China for enrollment.

原件
Original

☐ 申请表（全家人仅需填写一份申请表）
Application Form (One set for one family)

复印件
Copy

☐ 所有被保险人的身份证/护照
Passport/ID copies of all insured members

第三方服务提供商
万欣和（上海）企业服务有限公司
中国上海浦东峨山路91弄20号陆家嘴软件园
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