

CIGNA International

Claim Form

CIGNA International

CIGNA Worldwide Insurance Company
Connecticut General Life Insurance Company

Home Office: Wilmington, Delaware
Mailing Address: P.O. Box 15050
Wilmington, DE 19850

Phone: (800) 441.2668 (outside the USA, via ATT + access)
(302) 797.3100 (outside the USA, collect calls accepted)
Facsimile: (302) 797.3150 (inside the USA)
(800) 243.6998 (outside the USA, via ATT + access)
Website: <http://www.cigna.com/expatriates>



IMPORTANT INFORMATION: PLEASE READ

In order for your health claim to be considered for reimbursement, you must complete and sign this claim form. Please mail or fax this completed claim form with itemized bills and receipts to the address or fax number listed above. Please tape small receipts on 8.5 x 11 inch or ISO A4 paper. Please do not staple receipts to claim form.

Please print or type on this Claim Form. Please complete Sections A and B and Signature lines. Complete Section C if Wire Transfer of payment is requested. Complete Section D if other coverage is in effect or the claim is accident or work related. Complete a separate Claim Form for each family member.

SECTION A. EMPLOYEE AND PATIENT INFORMATION

Date of service, earliest date if multiple _____ (mm/dd/yyyy)	
Country where services were rendered _____	Diagnosis/Reason for treatment _____ (Please note diagnosis/reason for each service received)
Employer _____	CIGNA Employee ID Number
Employee's Name _____	Patient's Name _____
Employee's Date of Birth _____ (month) (day) (year)	Patient's Date of Birth _____ (month) (day) (year)
Mailing Address _____	
City _____ State/Province _____ Country _____	
Postal/Zip Code _____	
<i>Please provide telephone and facsimile numbers with country and city codes.</i>	
Home # _____	Work # _____ Fax # _____
E-mail Address _____	

SECTION B. PAYMENT INFORMATION. Please complete either Option #1 or Option #2 and indicate preferred currency for payment. If you would like to enroll for Electronic Funds Transfer (EFT) please contact us for an application. If already enrolled with EFT, we will automatically send payment via EFT unless noted otherwise below.

Please indicate currency preference _____ If currency is not specified, payment will be made in U.S. dollars.	
<input type="checkbox"/> OPTION #1 Payment to EMPLOYEE. Please indicate where you wish the payment to be sent <input type="checkbox"/> Check (Payment to Address as listed above) <input type="checkbox"/> US Electronic Funds Transfer (requires prior EFT enrollment) <input type="checkbox"/> International Wire Transfer (must complete section C) <input type="checkbox"/> Direct mail (check deposit to your bank account (US & Canada)) Bank account # _____ Bank name _____ Name on account _____ Bank Branch Address _____	<input type="checkbox"/> OPTION #2 Payment to PROVIDER of Service, e.g. hospital, physician. Provider Name _____ Provider Address _____ _____ City _____ State/Province _____ Country _____ Postal/Zip code _____ Telephone Number _____

SECTION C. WIRE TRANSFER REQUEST. Complete only if requesting payment via wire transfer.

Should you have specific questions regarding what **YOUR** bank needs in order to receive a wire transfer, please contact your bank directly.
Please note your bank or other intermediary banks may assess a fee for the receipt of a wire transfer; these fees are not reimbursable under this plan.

Beneficiary's Name(s) (exactly as it appears on the account): _____
Surname/Last First Name(s) Middle Initial

(if reflected on your account)

Beneficiary's Address: _____

Beneficiary's Phone Number: _____
Country code area code telephone number

Bank Account Number: _____

Swift Code: _____

Account Currency: _____

Bank Name: _____

Bank Address: _____

Bank Sort Code (6 digit code is required for transfers into the U.K. only): _____

RUT # (required for Chilean Accounts similar to a U.S. Social Security Number): _____

This request applies to:

- This claim only
- All claims until further notice

NOTE: Due to various lifting fees that may be imposed by banks we suggest that for amounts less than US\$1,000 you may be financially better served by requesting payment in the form of a check.

SECTION D. OTHER COVERAGE Complete only if other coverage is in effect or if the claim is accident or work related.

Does your family have any other employer-provided medical or dental insurance? Yes No. If yes, please provide:

- Insurance company name _____ Policy No. _____
- What is the effective date of coverage (when it began)? _____ Are your dependents covered? Yes No
- Is this claim accident or work related?
 Accident related (continue to no. 4) Work related (continue to no. 4)
 No, not accident or work related (go to signature section)
- Please provide a brief description of how the accident or work injury occurred.

- If claim is due to an accident, are you seeking reimbursement from another source? Yes No.
If yes, please indicate source _____

FRAUD NOTICE: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing false, incomplete or misleading information is guilty of a felony.

PAYMENT AUTHORIZATION: I authorize payment as indicated in Section B of this Claim Form.

EMPLOYEE'S SIGNATURE: _____ DATE: _____

PATIENT'S SIGNATURE AND RELEASE: (Parent or Guardian, if claim is for a minor). I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading, or incomplete information. I authorize the release of all records or other information which may be necessary to determine benefits payable.

PATIENT'S SIGNATURE: _____ **DATE:** _____