MEDICAL BENEFITS ABROAD CLAIM FORM

CIGNA International

Connecticut General Life Insurance Company
Home Office: Wilmington, Delaware
Mailing Address: P.O. Box 15111
Wilmington, DE 19850

Phone: (800) 243.1348 (outside the USA, via ATT + access)
(302) 797.3535 (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.cignaenvoy.com

IMPORTANT INFORMATION PLEASE READ

In order for your health claim to be considered for reimbursement, you must complete and sign this claim form. Please return this completed form along with your documentation / receipts from the treating physician or hospital including the date of treatment, the diagnosis, claim form, and charges for the treatment to the address listed above.

Please print or type on this Claim Form. Please complete Section A and B and Signatures 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 / PATIENT AND TRAVEL INFORMATION

Date of service, earliest date if multiple _____

Country where services were rendered _____ Diagnosis / Reason for treatment _____
(Please note diagnosis / reason for each service received)

Travel Dates: ***(required for claim submission)***

Departure from home country on: _____ Return to home country on: _____

Employer _____ Policy / Group Number _____

Employee's Name _____ Employee's Date of Birth _____

Patient's Name _____ Patient's Date of Birth _____

Mailing Address _____

City _____ State / Province _____ Country _____

Postal / Zip Code _____

Please provide telephone and facsimile numbers, with country and city codes

Home # _____ Work # _____ Fax # _____

SECTION B. PAYMENT INFORMATION

(Please complete either Option #1 or #2 and indicate preferred currency for payment)

Please indicate currency preference _____

If currency is not specified, payment will be made in US dollars

❒ **Option #1** Payment to EMPLOYEE

Please indicate where you wish the payment to be sent.

❑ Check (payment to Address as listed above)
❑ Wire Transfer (must complete section C)
❑ Direct Mail (check deposit to your bank account, US & Canada)

Bank Account # _____
Bank Name _____
Name on account _____
Bank Branch Address _____

❒ **Option #2** Payment to PROVIDER of Service
(e.g. hospital, physician, clinic)

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 that your bank or other intermediary banks may assess a fee for the receipt of a wire transfer; and these fees are not reimbursable under this plan.**

Beneficiary's Name as it appears on the account: _____

Beneficiary Address: _____

Beneficiary Phone Number: _____

Bank Account Number: _____

Bank Route / Swift Code: _____

Sort Code: _____

RUT# (required for Chilean Accounts): _____

Account Currency: _____

Bank Name: _____

Bank Address: _____

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 $1,000.00 you may be financially better served by requesting payment in the form of a check.

SECTION D. OTHER COVERGE INFORMATION (Complete only if other coverage is in effect or if the claim is accident or work related.)

Do you have any other insurance? ❑ Yes ❒ No If yes, please provide source of insurance.

1. Please indicate source _____
2. Is this claim accident or work related?
   - ❒ Accident related (continue to No. 3) ❒ Work related (continue to No. 3)
   - ❒ No, not an accident or work related (go to signature section)
3. Please provide a brief description of how the accident or work injury occurred:

   _____

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

DISCLOSURE: Information we collect about you will not be given to anyone, without your consent, except when it is necessary for conducting our business. The only individuals who have access to the information are CIGNA employees who service your policy or claims, and those who have insurance related, regulatory or legal need for the information. In other situations, we will ask for your written authorization to disclose information about you.

FRAUD NOTICE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any 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: _____