Cigna

Global Health Benefits

Medical Benefits Abroad

MBA claim form

Cigna Health and Life Insurance Company
Connecticut General Life Insurance Company
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001.302.797.3150

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.

Please print or type on this claim form. Please complete Sections A and B in their entirety and sign the completed form. 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 form for each family member.

Section A Employee/Patient and Travel Information

Date(s) of service, earliest date if multiple (MM/DD/YYYY):

Country where services were rendered: Country of Permanent Residence:

Diagnosis/Reason for treatment:

(Please note diagnosis/reason for each service rendered)

Travel Dates: (required for claim submission)

Departure from Country of Permanent Residence on: Return to Country of Permanent Residence on:

Employer Name: Policy/Group Number:

Employee's Name (Last): Patient's Name (Last):

Employee's Name (First): Patient's Name (First):

Employee's Date of birth (MM/DD/YYYY): Patient's Date of Birth (MM/DD/YYYY):

Employee's Home Country Mailing Address: City: State: Postal/Zip Code:

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

Home Number: Work Number: Fax Number:

Section B Payment Information

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 Deposit (check deposit to your bank account, US and Canada)

Bank Account Number:

Bank Name:

Name on account:

Bank Branch Address:

☐ **Option #2** Payment to **PROVIDER** of service

(e.g. hospital, doctor, clinic, etc.)

Doctor's Name:

Doctor's Address:

City:

State/Province:

Country:

Postal/Zip Code:

Telephone Number:

Section C Wire Transfer Request

Complete this section only if requesting payment via wire transfer.

If 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 asses a fee for the receipt of a wire transfer. These fees are not reimbursable under this plan.**

Beneficiary's Name as it appears on account:

Beneficiary Address:

Beneficiary Phone Number:

Bank Account Number:

Bank Route/Swift Code:

Sort Code:

RUT Number (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 $100.00 USD you may be financially better served by requesting payment in the form of a check.

Section D Other Coverage Information

Complete this section only if other coverage is in effect or if the claim is accident or work related.

1. Do you have any other insurance? ☐ Yes ☐ No

If yes, please provide source of insurance:

2. Is this claim accident or work related?

☐ Accident Related (Continue to Number 3) ☐ Work Related (Continue to Number 3) ☐ 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 your 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 defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

Payment Authorization: I authorize payment as indicated in Section B of this claim form.

Employee 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:**