

CIGNA International Medical/Dental/Vision Form



CIGNA INTERNATIONAL
EXPATRIATE BENEFITS

SECTION A : PATIENT'S DETAILS

To be completed by the insured person or his/her legal representative

1 Full Name	2 Employee's Name (if different)	
3 Membership Number	4 Relationship to Employee	
5 Patient's Date of Birth	6 Full Mailing Address of Employee	
7 Full Name of Employer		
8 State nature of illness		
9 Have you received full or partial reimbursement for these expenses from the local healthcare system or other health or travel insurance policy? Yes/No	Email address	
	Tel No	Fax No

10 If you have answered yes in section 9, please give details below (Full Name, Address of Insurance Company and Policy number)

SECTION B : PAYMENT DETAILS

To be completed by the insured person or his/her legal representative

11 List of expenses for which reimbursement is claimed and amount			12 State to whom you wish settlement paid and currency	
Treatment	Date	Amount	Payment to	Reimbursement Currency

13 Select payment method
 Cheque Bank Transfer
 ePayment Plus For this payment option you **must** enrol via the website, www.cigna.com/expatriate

14 If payment is to be sent to your bank account, please complete the following:

Bank Account No.	Bank Name
Sort Code	Bank Branch Address
Name of Account Holder (must be exact)	

15 I authorise the release of any medical information necessary to process this claim. To the best of my knowledge all the details given are true.

Signature of Insured Person or Legal Representative	Date
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Access to Medical Reports Act 1988 - Before your doctor can complete the form, you must give your consent. Before you give your consent you should be aware of your rights under the Act, which are summarised as follows: 1. You may withhold your consent. 2. You may see the report before it is sent to us within 21 days from the date of this report. 3. You may ask to see the report for up to six months after the report is completed. 4. You may ask the doctor to amend any part of the report which you consider to be incorrect or misleading. If the doctor does not agree with your request, you may attach your comments to the report. NB. The doctor may withhold all or part of the report from you if he considers that you may be physically or mentally harmed by it.

Patient Declaration. Having been made aware of my statutory rights under the **Access to Medical Reports Act 1988** in connection with my claim,
 1. I hereby consent to CIGNA seeking a medical report from my specialist or general practitioner as to the history and nature of the condition or its treatment. This consent only applies to the condition for which I am making a claim.
 2. I DO/DO NOT wish to see the report before it is sent to CIGNA.
 3. I authorise the doctor to disclose such information to CIGNA.

Data Protection Act 1998. We need your explicit approval to process our data as some of the information contained in the claim may be classified as sensitive data under the Act. Please confirm your agreement by signing below. Full details of your rights under both these Acts are available from CIGNA upon written request.

Signature of Patient (or Parent/Guardian if under 18)	Date
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SECTION C: MEDICAL INFORMATION

To be completed by treating Physician - PLEASE PRINT

(If your patient is claiming for vision please only complete section 20)

16 Please state the date of which the patient first consulted you for this condition

17 When did the symptoms first occur?

18 Please give your diagnosis of the illness/injury

19 Please give details of treatment

20 Please print your name and address and authenticate with an official practice stamp

Signature of treating Physician/Dentist

Date

Please return your completed claim form to:

For claim forms outside the USA, CIGNA International Expatriate Benefits, International Claims, 1 Knowe Road, Greenock PA15 4RJ
Tel: 44 1475 492197 Fax: 44 1475 492424 E-mail address: ice.team@cigna.com

For claim forms in the USA, CIGNA International Expatriate Benefits, International Claims, PO Box 15964, Wilmington, DE 19850-
Tel: 1 800 768 1725 Fax: 1 302 797 3150

CIGNA Life Insurance Company of Europe S.A.-N.V. and CIGNA Europe Insurance Company S.A.-N.V.,
registered in Belgium Avenue de Cortenbergh 52, 1000 Brussels, Belgium.
Regulated in Belgium by the Commission Bancaire, Financière et des Assurances (CBFA).
CIGNA European Services (UK) Ltd., registered office at 4th Floor, 45 London Road, Reigate, Surrey RH2 9PY.