MEDICAL AND VISION CLAIM FORM

HOW WE USE YOUR INFORMATION

We will collect, use, store, and disclose your personal information, including sensitive information (in particular, information relating to your medical history and any medical treatment you may have or have had), in accordance with relevant data protection legislation. We collect and will use your personal information, including sensitive information, for the purpose of carrying out our obligations under this plan.
We may share your information, including sensitive information, with other Cigna companies and authorised healthcare providers, where necessary to carry out our obligations under this plan. This statement also applies to personal information of any beneficiaries detailed on this application form. You have the right to request a copy of your personal information held by us, and beneficiaries under your policy have the right to request a copy of personal information we hold about them. We may charge a fee to provide this information.

PATIENT'S DETAILS

To be completed by the beneficiary or his/her legal representative

1 Patient name			
2 Policy ID		**3** Patient's date of birth	
4 Full mailing address of patient			
5 State nature of illness			

Email address		Tel no		Fax no	

6 Do you have any other health or travel insurance policy for which you may receive full or partial reimbursement for these expenses?	Yes		No	

If you have answered yes in section 6, please give details below:

Full name		Policy number	
Address of insurance company			

PAYMENT DETAILS

To be completed by the beneficiary or his/her legal representative

7 List of expenses for which reimbursement is claimed and amount			**8** State to whom you wish settlement paid and currency	
Treatment	Date	Amount	Payment to	Currency

9 Select payment method	**Cheque**		**Bank wire transfer**	

10 Should payment be sent to your bank account, please complete the following:

Bank account no.		Bank name	
Sort Code		Name of account holder	
Swift Code*		IBAN*	
Bank branch address:			

11 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.

I warrant and represent that I have each covered person's consent to disclose the personal information, including the sensitive personal information (e.g. medical information) contained in this form to you. I confirm that each covered person is aware of their duty to take reasonable care to answer questions accurately, honestly, completely and to the best of their knowledge.

(Please note that if you are declaring the above on another person's behalf, it is your obligation to keep evidence of the consent you are providing hereto of your covered family members' actual declarations and consents.)

Signature of insured person (or Legal Representative):	
Date	

*by providing this information, payment will be transferred more efficiently by the receiving bank

MEDICAL INFORMATION

To be completed by treating Physician – PLEASE PRINT			
12 Please give your diagnosis of the illness/injury, including details of when the symptoms first started			
13 Please give details of treatment			
14 Please print your name, medical profession and address and authenticate with an official practice stamp			
15 Signature of treating Physician		Date	

Please return your fully completed form along with the original receipt/invoices to:

Treatment incurred outside the USA send to:

Cigna Global Health Options
1 Knowe Road
Greenock
PA15 4RJ
Scotland

Tel: +44 (0) 1475 788182
Fax: +44 (0) 1475 492113
Email: cignaglobal_customer.care@cigna.com

Treatment incurred inside the USA send to:

Cigna International
PO Box 15964
Wilmington, Delaware 19850
United States of America

Tel: +44 (0) 1475 788182
Fax: 855 358 6457
Email: cignaglobal_customer.care@cigna.com

FRAUD NOTICE: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing deliberately false information, commits a fraudulent insurance act, which is a crime.

We will not deal with any claims which we believe to be fraudulent. Committing fraud may result in your policy being terminated, or we will investigate any claims which we believe to be fraudulent.

Your relevant Cigna contracting entity from those listed below will be detailed in your Policy Rules and Certificate of Insurance.
a) Cigna Life Insurance Company of Europe S.A-N.V.; or
b) Cigna Global Insurance Company Limited; or
c) Cigna Worldwide General Insurance Company Limited; or
d) Cigna Europe Insurance Company S.A-N.V.