# *Cigna Global Health Benefits Claim Form*

**Cigna Global Insurance Company Limited**
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**Cigna Life Insurance Company of Europe S.A.-N.V.**
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Global Health Benefits

**IMPORTANT INFORMATION: PLEASE READ** Submit this completed claim form with itemized bills and receipts to the address or fax number listed above. Tape small receipts on 8.5 x 11 inch or ISO A4 paper. Do not staple receipts to claim form. ***Complete a separate Claim Form for each patient.*** **In order for your health claim to be considered for reimbursement, you must complete and sign this claim form.**

## SECTION A: EMPLOYEE AND PATIENT INFORMATION

| COUNTRY WHERE SERVICES WERE RENDERED* | DIAGNOSIS/REASON FOR TREATMENT* | ID NUMBER* |
|---|---|---|
| | | |

| EMPLOYER | EMPLOYEE NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) * |
|---|---|
| | |

| PATIENT NAME (IF MULTIPLE, USE INDIVIDUAL CLAIM FORMS FOR EACH) * | PATIENT DATE OF BIRTH (MONTH/DAY/YEAR) * | HOME PHONE NUMBER |
|---|---|---|
| | | |

| PRIMARY MAILING ADDRESS (WHERE CHECK/EOB SHOULD BE SENT) | WORK PHONE NUMBER |
|---|---|
| | |

| CITY/STATE | COUNTRY/POSTAL CODE | EMAIL ADDRESS | FASCIMILE NUMBER |
|---|---|---|---|
| | | | |

## SECTION B: PAYMENT INFORMATION* (Incomplete or incorrect information may result in a check payment made in US Dollars and mailed to your Primary Mailing Address)

☐ PAY EMPLOYEE ☐ PAY PROVIDER

IF NEITHER OF THE ABOVE IS CHECKED PAYMENT WILL BE MADE TO THE EMPLOYEE. PLEASE BE ADVISED THAT IF THE PROVIDER OF SERVICE IS A PROVIDER IN THE US AND HOLDS A CONTRACT WITH Cigna, PAYMENT WILL BE MADE TO THE PROVIDER EVEN IF THIS SECTION INDICATES OTHERWISE. IF THE PROVIDER IS CONTRACTED WITH Cigna, THE PROVIDER WILL BE PAID BY Cigna AT THE CONTRACTED RATE. IF YOU HAVE ALREADY PAID FOR SERVICES, YOU SHOULD SEEK REIMBURSEMENT DIRECTLY FROM THE PROVIDER

IF PAYMENT IS BEING MADE TO **EMPLOYEE** – COMPLETE PAYMENT DETAILS BELOW

RESTRICTIONS TO EFT, EPAYMENT PLUS, WIRE TRANSFER OR PAYMENT CURRENCIES MAY AFFECT OUR ABILITY TO PAY CLAIMS AS REQUESTED

PAYMENT TYPE

**POINT OF CLAIM PAYMENT OPTIONS**

CHECK ☐ MAILED TO YOUR PRIMARY MAILING ADDRESS
☐ US DOLLAR
☐ OTHER CURRENCY (SPECIFY BELOW)

WIRE TRANSFER ☐ US OR INT'L CURRENCY TO AN INTERNATIONAL BANK. BANK MAY ASSESS FEES FOR RECEIPT OF ELECTRONIC WIRE PAYMENTS
**FILL OUT THE BANK DETAILS SECTION BELOW**

FOR OTHER AVAILABLE PAYMENT OPTIONS SEE THE BACK OF THIS CLAIM FORM MORE INFORMATION ALSO AVAILABE ON OUR WEBSITE www.CignaEnvoy.com

BANK DETAILS **THIS SECTION FOR WIRE TRANSFERS ONLY**

| NAME ON ACCOUNT | ACCOUNT NUMBER (INTERNATIONAL BANK ACCOUNT NUMBER – IBAN) |
|---|---|
| | |
| BANK NAME | BRANCH ADDRESS |
| | |
| BANK CODE (ABA / Routing / Swift / Bic / RUT / BSB / sort codes) | CITY/STATE |
| | |
| BANK ACCOUNT CURRENCY | COUNTRY/POSTAL CODE |
| | |

VERIFY ALL ACCOUNT INFORMATION, BANK CODE REQUIREMENTS AND CURRENCY REQUIREMENTS FOR YOUR BANKING COUNTRY TO ENSURE THE SUCCESSFUL TRANSMISSION OF YOUR PAYMENT. EFT, WIRE TRANSFERS, EPAYMENT PLUS MAY NOT BE AVAILABLE IN ALL COUNTRIES TO ALL MEMBERS. **INCURRED CURRENCY OR US DOLLAR CHECK MAY BE ISSUED AS A DEFAULT PAYMENT**

*Required information. Missing or incomplete information on this form will delay payment of your reimbursement.

## SECTION C: OTHER COVERAGE INFORMATION *(Complete only if other coverage is in effect or if the claim is accident or work related)*

**DO YOU OR THE PATIENT HAVE ANY OTHER INSURANCE?** ☐ **Yes** ☐ **No** **IF YES, PROVIDE THE NAME OF THE HEALTH INSURANCE CARRIER, EFFECTIVE DATE OF COVERAGE AND POLICY NUMBER**

PLEASE INDICATE SOURCE OF COVERAGE

**IS THE CLAIM ACCIDENT OR WORK RELATED?** ☐ **Yes** ☐ **No** **IF YES TO EITHER, PROVIDE THE ACCIDENT OR INJURY DETAILS**

PLEASE PROVIDE A DESCRIPTION OF HOW THE ACCIDENT OCCURRED: _____

**ARE YOU SEEKING REIMBURSEMENT FROM ANOTHER SOURCE?** ☐ **Yes** ☐ **No** **IF YES TO EITHER, INDICATE THE SOURCE**

REIMBURSEMENT SOURCE INFORMATION: _____

**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, which is a crime.

## SECTION D: PAYMENT AUTHORIZATION – I authorize payment as indicated in Section B of this Claim Form

**EMPLOYEE SIGNATURE:** _____ **DATE:** _____

**PATIENT'S SIGNATURE** (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 or misleading information. I certify that the information supplied is true and correct.

**PATIENT/GUARDIAN SIGNATURE:** _____ **DATE:** _____

### IMPORTANT PAYMENT INFORMATION

*ELECTRONIC FUNDS TRANSFER (EFT)

EFT is only available for electronic payments made in US Dollars to US Bank accounts. An EFT authorization form must be completed prior to claim submission. The form can be found on our website: www.CignaEnvoy.com, under Forms. Banking details will be updated within 10 business days after receiving the EFT authorization form. Within 10-15 business days after the update, your bank will verify if your account is ready to receive funds. Claim payments made in the interim of receiving the authorization will be made by check in US Dollars.

**EPAYMENT PLUS℠ (INT»L ACH)

International ACH payments are only available for electronic payments in the *United Kingdom, Spain, Germany, France, Belgium, Canada, Portugal, Hong Kong, Netherlands or Singapore* in the local currency of that country. Enrollment must be completed prior to claim submission. To enroll please access the ePayment Plus online enrollment section found on our website at: www.CignaEnvoy.com, in the Member Information section. Once enrolled, your claim reimbursements will be deposited electronically into the bank account you specify. If an electronic payment is rejected due to incorrect bank account information, a local currency or US dollar check may be issued until you correct your electronic account information through the website. To cancel electronic deposits to your account you must terminate your ePayment Plus account information through this website. Lifting fees and additional bank charges may apply - please contact your bank for details.

WIRE TRANSFERS

Wire transfers are only available for electronic payments made in Local Currency - wires will not be used to send US Dollars to a US Bank account. Wire transfers require complete and accurate information to be completed on the front of the claim form.

DEFAULT PAYMENT PROCESS

Missing or incomplete information on this form will delay payment of your reimbursement. If Payment Type selected is unavailable your claims reimbursement will be issued as a check and mailed to the primary mailing address stated in this form. Note: All currencies are not available for some countries. If a currency or payment method is not available, the default payment is a U.S. dollar check. If your bank information submitted for enrollment in EFT or ePayment Plus is incomplete or incorrect, your claims reimbursement will be issued as a check and mailed to the primary mailing address stated in this form. You will receive reimbursements through the method of choice, once the correct information for EFT or ePayment Plus is received.