

# 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.					
<b>(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.)</b>					
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](mailto: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](mailto: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 you 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.