MEDICAL CLAIM FORM

1. Please write clearly in black ink and **BLOCK CAPITALS**.
2. This claim form contains personal data. Please don't share this with members outside your family.
3. Please complete a separate claim form for each patient and for each currency.
4. Return this form with original invoices (no staples) to:
   Cigna, P.O. Box 451989, Sunrise FL 33345, USA

Name plan member

Personal reference n° /

Organisation

Address

Telephone

Email

PATIENT

Name

Date of birth D M Y Gender ◯ M ◯ F

Relationship ◯ Plan member ◯ Spouse/Partner ◯ Child ◯ Other, please specify

CLAIM INFORMATION

Is the claim (partially) related to an accident? ◯ No ◯ Yes ◯ Yes, work related

↳ If yes, also complete the **Notification of accident form**.

Is the claim covered by another insurance? ◯ No ◯ Yes

↳ If yes, specify the amount and the insurance company and include the insurance statements (settlement notes, invoices, etc.)

Amount and currency Insurance company

Currency	Amount	Invoice date	Nature of expenses	Additional info (e.g. diagnosis)
		D M Y		
		D M Y		
		D M Y		
		D M Y		
		D M Y		
Total	0	Main country of treatment		

PAYMENT INFORMATION - COMPLETE ONLY IN CASE OF CHANGE

◯ Bank transfer ◯ Cheque Preferred currency of reimbursement

The currencies are limited by the contract. If this currency is different from that of your bank account, your bank could charge you fees at your expense.

Name account holder

Account n° or IBAN

BIC/Swift code Bank ID

Full bank name and address

I accept the terms and conditions. I certify that the above information is to the best of my knowledge and belief correct and true. The issuance of false claims, the provisions of misleading information or the withholding of information related thereto is an offence punishable by Law. I hereby confirm that I have read and fully understood Cigna's Data Protection Notice (https://www.cignahealthbenefits.com/en/privacy). If I provide Cigna with personal information relating to others, I will make them aware of Cigna's Data Protection Notice.

Date D M Y

Signature of the plan member

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