

## Medical and Vision claim form

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: <span style="float: right;">Fax no:</span>
6 Do you have any other health or travel insurance policy for which you may receive full or partial reimbursement for these expenses? Yes <input type="checkbox"/> No <input type="checkbox"/>	
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 <input type="checkbox"/> Bank Wire Transfer <input type="checkbox"/>	
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.	
Signature of insured person (or Legal Representative):	Date:

## 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: +44 (0) 1475 492113

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 Global Insurance Company; or
- b) Cigna Worldwide Life Insurance Company Limited; or
- c) Cigna Europe Insurance Company S.A-N.V (Swiss Branch); or
- d) Cigna Life Insurance Company of Europe S.A-N.V; or
- e) Cigna Europe Insurance Company S.A-N.V (Singapore Branch)