Cigna Global Health Options

Medical and Vision claim form

cigna healthcare

SECTION A

PATIENT'S DETAILS

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

DEPENDANTS

First Name		Surname	
Date of birth (DD/MM/YYYY)		Policy ID	
Full mailing address of patient			
State nature of illness			
Email address			
Tel no:		Fax no:	

Do you or anyone to be covered under this policy have any appointments, treatment, tests or investigations planned or pending?	**Yes**		**No**
If you have answered yes in section above, please give details below:			
Full name			
Policy number			
Address of insurance company			

SECTION B

PAYMENT DETAILS

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

List of expenses for which reimbursement is claimed and amount	State to whom you wish settlement paid and currency

Treatment	Date	Amount	Payment to	Currency

Select payment method	**Cheque**		**Bank Wire Transfer**
Should payment be sent to your bank account, please complete the following:			

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

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

SECTION C

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 (DD/MM/YYYY)	

SECTION D

MEDICAL INFORMATION

To be completed by treating Physician – PLEASE PRINT

Please give your diagnosis of the illness/injury, including details of when the symptoms first started:	Please give details of treatment:

Please print your name, medical profession and address and authenticate with an official practice stamp.

Signature of insured person (or Legal Representative):	
Date (DD/MM/YYYY)	

FRAUD NOTICE

Any person who, knowingly and with intent to defraud any insurance company or other person, fi les 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 Global Insurance Company Limited; or
b) Cigna Life Insurance Company of Europe S.A-N.V; or
c) Cigna Worldwide General Insurance Company Limited; or
d) Cigna Europe Insurance Company S.A-N.V (UK Branch); or
e) Cigna Europe Insurance Company S.A-N.V (Singapore Branch)

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

Treatment incurred outside the USA send to:
Cigna Global Health Options
I Knowe Road
Greenock
PAI5 4RJ
Scotland
Tel: +44 (0) I475 788I82
Fax: +44 (0) I475 492II3
Email: cignaglobal_customer.care@cigna.com

Treatment incurred inside the USA send to:
Cigna International
PO Box I5964
Wilmington, Delaware I9850
United States of America
Tel: +44 (0) I475 788I82
Fax: +44 (0) I475 492II3
Email: cignaglobal_customer.care@cigna.com

591797 MEDICAL AND VISION CLAIM FORM 07/2024