Aetna™

Group Health Insurance Benefits
Claim Instruction

United Nations
New York, NY 10017

HOW To File A Claim

1. Complete, date and sign Part A of the "Statement of Claim" on the reverse side of this form. Be sure to complete each item on the form to avoid a delay in the payment of your claim. In your absence your spouse may sign for you. If neither you nor your spouse is able to sign because of illness or other valid reason, the form may be signed on you behalf by a guardian or other authorized person.
2. Have your doctor complete Part B (Attending Physician's Statement). If you had more than one doctor for anyone illness or injury, normally only one statement is needed, to be completed by the one who rendered the most service or who performed surgery. Aetna U.S. Healthcare® may request additional Attending Physician's Statements if necessary.
3. If there is no "Attending Physician's Statement", attach to Part A all bills for which you are claiming benefits. Each bill must show (a) name of patient, (b) date and charge for each service rendered, (c) the illness or injury for each item of expense. If the bill does not show this information, write it on the bill yourself and sign your name.

   Your prescription drug bills should be claimed using Part C below. However, if you prefer to send in your drug bills, rather than the Prescription Drug Record, please be sure that bills also show the prescription number, the nature of illness or injury, the name of the drug, if available, the name of the prescribing physician.
4. Each time additional bills are submitted with respect to the same illness, Part A of the "Statement of Claim", form should be completed and submitted with the bills. However, a new "Attending Physician's Statement" (Part B) need not be completed unless Aetna U.S. Healthcare requests it.
5. Separate claim forms must be submitted for each family member for whom a claim is being made.
6. For your convenience you may wish to accumulate small bills and submit them to the Aetna U.S. Healthcare on a monthly or quarterly basis.

Where To File A Claim

All claims should be submitted to :

Aetna Inc.
P.O. Box 981106
El Paso, TX 79998-1106

Claim forms may be obtained form the nearest United Nations office. Replacement forms will be sent to you by Aetna U.S. Healthcare each time a claim payment is made.

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant. California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.

Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.

Part C
Prescription Drug Record

Name of Drug Dose Per Day Strength (ex., 25 mg., 0.5 Gm)	Date Purchased	Nature of Illness or Injury	Prescription Number	Prescribing Physician	Amount Charged	Name of Pharmacy

I hereby certify the above drugs and medicines were necessary for treatment of the illness/injury reported and were purchased by me for individual names on Part A of this form.

I understand the bills, prescriptions and other data pertaining to the above items are to be retained by me for 12 months from this date and are to be made available to Aetna U.S. Healthcare if requested.

Signed _____ Date _____

GC-5524 (2-00)

STATEMENT OF CLAIM
for Group Health Insurance Benefits

United Nations
New York, NY 10017

PART A. See instructions on reverse side before completing this form. Please type or clearly print all information, except signature.

1. Subscriber's Name (First) (Middle Initial) (Last)					2. Telephone Number
3. Subscriber's Address (Number) (Street)			(City)	(State)	(Zip Code)
4. Patient's Name (First)	(Middle Initial)	(Last)	6. Sex ☐ Male ☐ Female		7. Birthdate (MM/DD/YYYY)
7. Relationship of Patient to Subscriber ☐ Self ☐ Spouse ☐ Child	8. Patient's Employer (if any)				8A. Subscriber Payroll Index Number

9. Was illness or injury related to employment? ☐ Yes ☐ No

10. Has the Subscriber terminated employment with the United Nations? ☐ Yes ☐ No
If Yes, separation date ____ ____ / ____ ____ / ____ ____
(Month) (Day) (Year)
If Yes, is the patient covered under the U.N. After-Service Health Insurance Scheme ☐ Yes ☐ No

10A. After Service Health Insurance Account Number

11. Are you or any of your family members covered through any other Group Plan which provides Medical Benefits or Services? ☐ Yes ☐ No
If Yes, give name and address of organization providing services: _____

12. Were any of the medical services or supplies for which this claim is being mad, furnished or paid for by a Government Agency?
By U. S. Medicare ☐ Yes ☐ No Other ☐ Yes ☐ No

13. Has a "Statement of Claim" been submitted previously for this illness? ☐ Yes ☐ No

AUTHORIZATION TO PAY BENEFITS: (Check one)

☐ PHYSICIAN: I hereby authorize payment to be made directly to the undersigned physician for the applicable Surgical and/or Medical benefits; or

☐ SUBSCRIBER: I request that payment be made to me.

I certify that the above statements are correct and hereby authorize any doctor or organization to provide pertinent records in connection with this claim to Aetna U.S. Healthcare, on a confidential basis, on request.

Date _____ Signature of Subscriber or Spouse _____

PART B. ATTENDING PHYSCIAN'S STATEMENT Please complete and return to Subscriber or Patient.

Diagnosis, Concurrent Conditions and Symptoms (If diagnosis code other than ICDA* used, give name)

Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No

Pregnancy? ☐ Yes ☐ No If yes, approximate date pregnancy commenced _____

REPORT OF SERVICES (OR ATTACH ITEMIZED BILL) (IF PREVIOUS FORM SUBMITTED TO AETNA U.S. HEALTHCARE™ FOR THE SAME ILLNESS, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT)

Date of Services	Place of Service†	Description of Surgical or Medical Services Rendered	Procedure Code — If Used (If code other than CPT** used, give name)	Charges

†O - Doctor's Office IH - Inpatient Hospital C - Consultation (list referring physician)
H - Patient's Home OH - Outpatient Hospital L - Outpatient or out of hospital lab. test
* ICDA - International Classification of Diseases X - Diagnostic X-rays
** CPT - Current Procedural Terminology (current edition) OL - Other locations or services (specify)

Total Charges ▶ $ _____
Amount Paid ▶ $ _____
Balance Due ▶ $ _____

Physician's Name & Address (include zip code)

Telephone Number ( )

For U.S. Practitioners Only
MUST BE FURNISHED UNDER AUTHORITY OF LAW
Individual Practitioners - SS# __ __ __ - __ __ - __ __ __ __
(U.S. Practitioners Only)
All Others - Employer I.D.# _____

Physician's Signature

Date