



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 69, 2140 Antwerpen, Belgium

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)
<input type="text"/>	<input type="text"/>	D <input type="text"/> M <input type="text"/> Y <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	D <input type="text"/> M <input type="text"/> Y <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	D <input type="text"/> M <input type="text"/> Y <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	D <input type="text"/> M <input type="text"/> Y <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	D <input type="text"/> M <input type="text"/> Y <input type="text"/>	<input type="text"/>	<input type="text"/>
Total <input type="text"/>		Main country of treatment <input type="text"/>		

PAYMENT INFORMATION - COMPLETE ONLY IN CASE OF REIMBURSEMENT HIGHER THAN 2,500 USD.

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

In view of a smooth administration of the contract and/or settlement of the insurance claim, and only for that purpose, I hereby give my specific and informed consent regarding the processing of the medical data concerning myself and/or the members of my family (article 7 of the Belgian law of December 8, 1992 concerning the private life). 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 Privacy policy (<https://www.cignahealthbenefits.com/en/privacy>) and give my consent to the processing of my personal information (including medical data) as defined in Cigna's Privacy policy.

Date D M Y

Signature of the plan member