Please return your completed claim form to:
For claim forms outside the USA: Cigna Global Health Benefits, 1 Knowe Road, Greenock, Scotland, PA15 4RJ
Tel: +44 (0) 1475 492197 Fax: +44 (0) 1475 492424 E-mail address: ice.team@cigna.com

For claim forms in the USA: Cigna Global Health Benefits, PO Box 15050, Wilmington, DE 19850-5050 USA
Tel: 1 800 768 1725 Fax: 1 302 797 3150

# Global Health Benefits Medical/ Dental/ Vision Form

## Section A : Patient's Details

To be completed by the insured person or his/her legal representative

| | |
|---|---|
| 1 Full Name | 2 Employee's Name (if different) |
| 3 Customer ID Number | 4 Relationship to Employee |
| 5 Patient's Date of Birth | 6 Full Mailing Address of Employee |
| 7 Full Name of Employer | |
| 8 State nature of illness | |
| 9 When did symptoms first occur/when was condition first diagnosed? | Email address |
| | Tel No Fax No |

10 Are you eligible for full or partial reimbursement for these expenses from another insurer? Yes/No

11 If you have answered yes in section 10, please give details below (Full Name, Address of Insurance Company and Policy number)

## Section B : Payment Details

To be completed by the insured person or his/her legal representative

12 List of expenses for which reimbursement is claimed and amount and currency

13 State to whom you wish settlement paid

| Treatment | Date | Amount and currency | Payment to |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

14 Select payment method Cheque ☐ Bank Transfer ☐
ePayment Plus ☐ For this payment option you must enrol via the website, www.CignaEnvoy.com

15 State reimbursement currency that payment should be made
(if reimbursement currency is EURO, please supply both IBAN and SWIFT codes below)

16 If payment is to be sent to your bank account, please complete the following:

| | |
|---|---|
| Bank Account No. | Bank Name |
| Sort Code | Bank Branch Address |
| Swift Code* | IBAN* |

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

Name of Account Holder **(must be exact)**

17 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

**Consent to obtain a Medical Report** - To process your claim we may need to ask your doctor for a medical report. To allow us to do this, we need you to give your consent. You have three options:1. You may withhold your consent. 2. You may give your consent, but ask to see the report before it is sent to us within 21 days from the date of the report. 3. You can give your consent. You may ask to see the report for up to six months after the report is completed. You may ask the doctor to amend any part of the report which you consider to be incorrect or misleading. If the doctor does not agree with your request, you may attach your comments to the report. The doctor may withhold all or part of the report from you if he considers that you may be physically or mentally harmed by it.

**Patient Declaration** - Having been made aware of my rights,

1. I hereby consent to Cigna seeking a medical report from my specialist or general practitioner as to the history and nature of the condition or its treatment. This consent only applies to the condition for which I am making a claim.
2. I DO/DO NOT wish to see the report before it is sent to Cigna.
3. I authorise the doctor to disclose such information to Cigna.

**Data Protection** - We also need your explicit approval to process any sensitive medical data in relation to your claim. Medical information will be kept confidential and only disclosed to authorised parties. Please confirm your consent by signing below.

Signature of Patient (or Parent/Guardian if under 18) Date

| PREVENTATIVE TREATMENT | | | | | |
|---|---|---|---|---|---|
| CODE | TREATMENT | NO OF UNITS | TOOTH NUMBER | DATE OF TREATMENT | CHARGE TO PATIENT |
| | **EXAMINATIONS** | | | | |
| A01 | Normal | | | | |
| A11 | Extensive | | | | |
| A21 | Full Case Assessment | | | | |
| | **X-RAYS** | | | | |
| B01 | Bitewing | | | | |
| B02 | Intra Oral | | | | |
| B03 | O.P.G. | | | | |
| | **SCALING AND POLISHING** | | | | |
| E01 | One Visit | | | | |
| | **MISCELLANEOUS TREATMENT** | | | | |
| D01 | Fissure Sealants | | | | |
| D11 | Topical Fluoride Application | | | | |
| M0U | Occlusal Splint | | | | |

| MINOR TREATMENT | | | | | |
|---|---|---|---|---|---|
| | **FILLINGS** | | | | |
| G01 | Amalgam-One Surface | | | | |
| G02 | Amalgam-Two+Surfaces | | | | |
| G03 | Amalgam-Three+Surfaces | | | | |
| G21 | Composite Anterior-One Surface | | | | |
| G22 | Composite Anterior-Two+Surfaces | | | | |
| | **ROOT CANAL TREATMENT** | | | | |
| H01 | Upper & Lower Anterior (1 root) | | | | |
| H02 | Upper Premolar (2 roots) | | | | |
| H03 | Lower Premolar (1 root) | | | | |
| H04 | Molars (3 + roots) | | | | |
| | **EXTRACTIONS** | | | | |
| L01 | Single | | | | |
| L02 | Per additional tooth | | | | |
| N11 | Post Operative Care | | | | |

| MAJOR TREATMENT | | | | | |
|---|---|---|---|---|---|
| CODE | TREATMENT | NO OF UNITS | TOOTH NUMBER | DATE OF TREATMENT | CHARGE TO PATIENT |
| | PERIODONTAL TREATMENT (NON SURGICAL) | | | | |
| E21 | Prolonged (Curettage/Root Planing) | | | | |
| F51 | Splinting | | | | |
| | PERIODONTAL TREATMENT (SURGICAL) | | | | |
| F01 | Gingivectomy | | | | |
| F11 | Mucoperio, Flap Bone Surgery | | | | |
| | DENTURES - METAL/ACRYLIC | | | | |
| R63 | Additional Tooth | | | | |
| R61 | Addition of Clasp | | | | |
| K71 | Denture Repair | | | | |
| | CROWNS/BRIDGES | | | | |
| J01 | Veneers (per tooth) | | | | |
| K32 | Adhesive Bridges | | | | |
| K41 | Conventional Bridgework | | | | |
| K12 | Standard Post & Core | | | | |
| K11 | Gold Post & Core | | | | |
| K07 | Bonded Precious Crown | | | | |
| K05 | Bonded Non Precious Crown | | | | |
| K08 | Full Cast Crown | | | | |
| K06 | Full Porcelain Crown | | | | |
| | INLAYS | | | | |
| K02 | Precious | | | | |
| K01 | Non Precious | | | | |
| K03 | Porcelain | | | | |

**Total**