Request for prior approval of out-of-country care

Staff member (to be completed by the staff member)

NAME - FIRST NAME

CIGNA PERS. REF. NO. (UPI NO.) /

COUNTRY OF ASSIGNMENT

DAYTIME PHONE NUMBER

Patient's details (if the patient is not the staff member)

NAME - FIRST NAME

DATE OF BIRTH (D - M - Y) GENDER ☐ M ☐ F

RELATIONSHIP ☐ SPOUSE OR DOMESTIC PARTNER ☐ CHILD

Medical information (to be completed by the attending physician)

NAME - FIRST NAME

SPECIALTY

ADDRESS

PHONE NUMBER FAX

EMAIL

DIAGNOSIS

REASON FOR REFERRAL - A DETAILED MEDICAL REPORT WITH MEDICAL HISTORY AND PREVIOUS TREATMENTS MUST BE ATTACHED.

Physician's seal and signature

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.

DATE SEAL AND SIGNATURE

Signature of the staff member

To intentionally provide false or misleading information with respect to the Medical Benefits Plan (MBP) may be misconduct under Staff Rule 3.00 and/or Staff Rule 8.01, and therefore subject to disciplinary measures, including termination of employment with the Bank Group. It may also result in the denial of benefits or termination of coverage, as appropriate. Also, in some jurisdictions, insurance fraud is a crime that may result in a penalty of imprisonment and/or fine.
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

Cigna pers. ref. no. (UPI no.) /

have read the benefit policy on out of county care for the World Bank Group MBP. I understand that request for referral is not guaranteed for approval. I also understand that I am responsible for any costs that may arise that are not covered under the Medical Benefits Plan.

☐ REQUEST FOR APPROVAL FOR CARE IN ☐ TRAVEL BENEFIT REQUEST

COMMENTS

DATE SIGNATURE