



# MEDICAL AND DENTAL 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

Pers. reference n° (UPI)  /

Plan

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	Diagnosis
<input type="text"/>	<input type="text"/>	D <input type="text"/> <input type="text"/> M <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	D <input type="text"/> <input type="text"/> M <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	D <input type="text"/> <input type="text"/> M <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	D <input type="text"/> <input type="text"/> M <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	D <input type="text"/> <input type="text"/> M <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>

Total  Main country of treatment

## PAYMENT INFORMATION (active staff under the Medical Benefits Plan 'MBP' will be reimbursed through Payroll)

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

To intentionally provide false or misleading information with respect to the Medical Benefits Plan (MBP) or Medical Insurance Plan (MIP) 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 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. The information provided on or attached to this form may be disclosed to other persons or entities for the purpose of processing this claim and performing medical insurance plan administration.

Date D   M   Y

Signature of the plan member