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 ☐ SEPA ☐ 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