

Al WorldTraveler^{sм} Claim Form

Aetna International <u>Please also complete Page 2 of this form.</u>

member. Please tape small receipts on a full size sheet of paper.							
Ae Po	netna International/Aetna PO Box 981543	Telephone:		7-301-5042 (outside the USA, via AT&T + access) 3-775-0239 (direct or collect outside the USA)			
	El Paso, TX 79998-1543 JSA	Facsimile:		00-475-8751 (outside the USA, via AT&T + access) 60-975-1741 (inside the USA)			
		E-mail:	aiservice@ae	tna.com			
1.	Employee Information						
	Employer Name/Group Number 299440- Employee's Name						
	(First Name, Middle Initial, Last Name/Surna	ame)	 				
	Identification Number (Aetna assigned upon receipt of initial claim, or refer to the Explana		FOPa) from provi	aug Al WorldTravolor of	im oubmico	ione \	
	Employee's Birthdate (mm/dd/yyyy) /	/ Berients (I		er 🔲 Male 🔲 Femal		10115.)	
	Street		Gend	ei 🔲 iviale 🔲 i eilial	C		
	City State/Province						
	_ `	ountry Postal/ZIP Code					
	Employee's Telephone Number (Include Country Code)						
	Employee's Home Country		_ Dates of Trav	el			
	Employee's Primary E-Mail Address(E-mail addresses are strongly encouraged in the event additional information is needed to process your claim.)						
	(E-mail addresses are strongly encouraged in the event addition	nai information is	s needed to proc	ess your ciaim.)			
2.	2. Patient Information						
	Patient's Name (First Name, Middle Initial, Last Name/Surname)						
	Relationship: Self Spouse Child Other Patient's Birthdate (mm/dd/yyyy) / / / /	/	Gend	er 🗌 Male 🗌 Femal	е		
3. Summary of Medical and Pharmacy Services (Please include diagnosis or reason for treatment for each service received.)							
(n	Provider's (physician, clinic, hospital, pharmacy) Name and Address Service (If the Provider's name and address is on receipts, write "see receipts") Description Name of M Drug/E (If hospital inpatient or	ledication/ Device I, indicate	Diagnosis eason for visit)	City/State/ Province/Country of Claim	Currency of Claim	Total Charge	
<u>_</u>	Claim Information						
-	If Yes is answered to either question below, c and d in this sec	tion must be con	npleted.				
	a. Is the claim related to a work related accident or condition?						
	b. Is the claim related to an accidental injury?						
	c. Accident Date (mm/dd/yyyy) / /		Time		_ AM	☐ PM	
d. Description of Accident (How and Where)							
	<u> </u>						

E	Employee's Name				
	(First Name, Middle Initial, Last Name/Surname)				
5.	Summary of Reimbursement (Method/Currency Type) – Only one method of reimbursement and currency will be honored per claim form. (Unless otherwise indicated, reimbursements will be made via US\$ check and payable to the party to which payment is sent.)				
	Use the information provided below to send any applicable	le reimbursement payment to:			
	Requested Reimbursement Method	Country/Currency Type for Reimbursement (i.e., Great Britain / Pounds) If the currency you have elected is not available for the method requested, we will default reimbursement to US\$.			
	☐ Funds Transfer (Preferred) The most efficient method of receiving your benefits reimbursement is via Funds Transfer. Please check with your bank for help with providing the appropriate instructions to Al.				
	☐ Check	(Complete the Country/Currency and go to Section 8.)			
6.	Bank Information				
	Primary Bank –The following information is required if you have elected Funds Transfer as your preferred method for reimbursements. Al will transfer funds to your bank at no cost to you; however, we encourage you to check with your bank to determine any additional fees your bank may charge you for receiving Funds Transfer(s).				
	Bank Account Number				
	Name of Accountholder (As it appears on the Bank Statement)				
	Bank Identification Code/Routing Number				
	S.W.I.F.T./BIC Code (wire only) CHIPS UID Federal ABA Bank Sort ID BAN Other				
	Bank Name				
	Bank Address (Include Country)				
	Bank Telephone Number (Include Country Code)				
7.	Other Health Coverage/Scheme				
	Are any family members' expenses covered by another health plan/scheme, Medicare, or any U.S. Federal, U.S. State, National, Social government plan? Yes No If "Yes," please complete information below.				
	Name and Relationship of the Family Member (First Name, Middle Initial, Last Name/Surname)				
	Family Members Birthdate (mm/dd/yyyy) /	/ Gender Male Female			
	Name of other Insurance Company or Type of Insurance				
8.	8. Authorization (Required)				
	For All Electronic Deposits: I hereby authorize Aetna Life & Casualty (Bermuda) Ltd., Aetna Life Insurance Company, and any of their affiliated companies ("Aetna") and/or their dedicated Agents to make payments of any benefits payable to me and/or my dependents, by crediting such payments to my account at the bank or financial institution named on this form. I agree to notify Aetna in writing of any changes relating to the information provided on this form or withdrawal of this authorization. I agree that if, for any reason, unearned benefit payments are deposited into my account, I will immediately repay the full amount of any such payments. I further agree that if I do not immediately repay such payments, I will personally be liable for all costs of collection (including reasonable attorney's fees and the maximum interest permitted by law).				
	Medical and Pharmacy Authorization. Must be signed and Dated: I authorize all physicians, other health professionals, pharmacies/pharmacists, hospitals and health care institutions to provide Aetna and any independent parties acting on Aetna's behalf or with whom Aetna has contracted, information concerning health care, advice, treatment or supplies provided to the Patient (including that related to mental illness and/or AIDS/ARC/HIV). This information will be used for the purposes of evaluating and administering claims. Aetna may provide the employer named on this form with any benefit calculation used in the payment of this claim for the purpose of reviewing the experience and operation of the policy/contract. This authorization is valid for the term of the policy or contract under which a claim is submitted. I know I have a right to receive a copy of this authorization upon request and agree that a copy of this authorization is as valid as the original.				
	Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant.				
	You may elect to use an electronic form of signature on this <u>claim</u> form confirming your verification and declaration to the details given above. For the avoidance of doubt such electronic signature will be valid and binding as if you had provided your original signature. We may rely on such electronic signature as a binding verification and declaration confirming that the information above is accurate and not misleading in all respects.				
1	Patient's or Authorized Person's Signature	Date (mm/dd/yyyy)			