MEDICAL 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

Personal reference n° /

Organisation

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**.

Please attach your JSIS reimbursement sheet(s) and mention the diagnosis.

Sheet 1: diagnose

Sheet 2: diagnose

Sheet 3: diagnose

Sheet 4: diagnose

Sheet 5: diagnose

PAYMENT INFORMATION - COMPLETE ONLY IN CASE OF CHANGE

◯ 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

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

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