

# CIGNA CARE CONNECT CLAIM FORM



1. PATIENT INFORMATION (All fields are mandatory)			
Patient's Membership ID:		Patient's Name:	
Employee's name (If different from Patient):		Email :	
2. MEDICAL INFORMATION			
Claim Type: <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Maternity <input type="checkbox"/> Wellness			Referral Letter: <input type="checkbox"/> (Check to indicate yes)
Visit Date	Provider Name	Diagnosis (e.g. headache, cold etc.)	Receipt Amount
<b>Total Amount</b>			
3. CLAIMS PAYMENT DETAILS (Select one of the methods of payment specified below)			
A - <input type="checkbox"/> I authorise Cigna to make ELECTRONIC TRANSFER into my Singapore bank account.			
Account Holder Name:			
Bank Name:		Bank Account No.:	
Bank Code:		Branch Code:	
B - <input type="checkbox"/> I authorise Cigna to pay my reimbursement claims via cheque as per the provided details below.			
Beneficiary Name:		Town/City:	
Building No./Name:	Area/Postal Code:	Country:	
4. DECLARATION AND AUTHORISATION			
<p>1. I certify, to the best of my knowledge, that my claims submission does not contain any false or misleading information. I certify that the information supplied is true and correct; and I have not withheld any material fact from Cigna Europe Insurance Company S.A.-N.V. Singapore Branch ("Cigna") (including its appointed administrator, Alliance Medinet Pte. Ltd. (a subsidiary of Alliance Healthcare Group Pte. Ltd.) ("Alliance")). I authorise payment as indicated in the payment section details. I am aware and acknowledge that any person who,</p> <p>a. knowingly and with intent to defraud any insurance company or other person;</p> <p>b. files an application for insurance or statement of claim containing any false information; or</p> <p>c. conceals for the purpose of misleading, information concerning any material fact thereto;</p> <p>may commit a criminal offence.</p> <p>2. I understand that submission of original bills and itemised receipts for Outpatient claims is NOT required as long as I have submitted the scanned receipts to Cigna. Original outpatient medical bills and itemised receipts however must be retained by me for at least 6 months from date of this submission and be made available upon request for future audit purposes, failing which my claims submission may be denied.</p> <p>3. I hereby authorise, agree and consent to:</p> <p>a. Cigna and Alliance requesting from any relevant medical source (including doctors, hospitals, clinics, medical examiners, laboratories and diagnostics centres) (collectively known as, "Medical Source"), all information with respect to any illness, injury, medical history, prescriptions, consultation, or treatment and copies of all hospital or medical records concerning myself or my eligible dependant at any time, and authorise the Medical Source to disclose all such information to Cigna and its authorised representative (including its appointed administrator, Alliance) for the purpose of processing my claims submission and other relevant administrative purposes in administering the Cigna Care Connect insurance plan; and</p> <p>b. Cigna and its related corporations (collectively, the "Companies"), as well as the Companies' authorised service providers (including its appointed administrator, Alliance) and relevant third parties, collecting, using, processing and/or disclosing my personal data (including my eligible dependant's personal data) for purposes reasonably required by the Companies to process my claims submission, for other administrative purposes in administering the Cigna Care Connect insurance plan, as well as such other purposes described in Cigna's prevailing Personal Data Protection Policy. Cigna's Personal Data Protection Policy is accessible from Cigna's website, which I confirm I have read and understood, and agree to be bound by.</p> <p>For the purposes of these Terms and Conditions, "personal data" shall have the same meaning as set forth in the Singapore Personal Data Protection Act 2012.</p> <p>4. I represent and warrant that I have obtained the consent of each of my eligible dependants for the use, collection, processing and disclosure of their personal data and information by the Companies and the Companies' authorised service providers, including Alliance, in accordance with and for the purposes set out in Paragraph 3 above. I agree to indemnify the Companies and the Companies' authorised service providers, including Alliance, from and against all claims, damages, expenses, costs and liabilities arising in connection with any breach of the foregoing representation and warranty.</p> <p>5. I agree that Cigna (including Alliance, on behalf of Cigna) shall have the right to recover any amounts from me (including via deduction or set off from any sums payable to me) that exceed the coverage of the Cigna Care Connect insurance plan and/or are not covered thereunder.</p> <p>6. This declaration and authorisation shall bind my/our successors and assignees, and remains valid, notwithstanding death, irrespective of whether or not my claim is accepted by Cigna.</p>			
Signature of patient _____		Signature of Employee* _____ (in the capacity as parent or legal guardian if patient is dependant of the employee who is below 18 years of age)	Date: _____ (DD / MM / YYYY)