Cigna

NAVIGATOR
Insurance Brokers Ltd.

Unit 8E Golden Sun Centre 223 Wing Lok St Sheung Wan HK
Tel. (852) 2530 2530 Fax (852) 2530 2535
Email: crew@navigator-insurance.com
www.navigator-insurance.com

Global Health Benefits

International Claim Form

SECTION A : PATIENT'S DETAILS

To be completed by the insured person or his/her legal representative

1. Patient's Full Name	2. Employee's Name (if different)
3. Membership 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. Are you eligible for full or partial reimbursement for these expenses from another insurer? Yes ☐ No ☐	Email Address
	Tel No Fax No

10. If you have answered yes in section 9, 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

11. List of expenses for which reimbursement is claimed and amount and currency			12. State to whom you wish settlement paid
Treatment	Date	Amount and Currency	Payment to

13. Select Payment Method
Cheque ☐ Bank Transfer ☐
ePayment Plus ☐ For this payment option you must enrol via the website www.cigna.com/expatriate

14. State reimbursement currency that payment should be made in.
(if reimbursement currency is EURO, please supply both IBAN and SWIFT codes below)

15. 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 to the receiving bank.

Name of Account Holder (must be exact)

16. 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 _____

Dental Claims - to be completed by Dentist

CODE	TREATMENT	NO OF UNITS	TOOTH NUMBER	DATE OF TREATMENT	CHARGE TO PATIENT
A01	Normal				
A11	Extensive				
A21	Full Case Assessment				
B01	Bitewing				
B02	Intra Oral				
B03	O.P.G.				
E01	One Visit				
D01	Fissure Sealants				
D11	Topical Fluoride Application				
M0U	Occlusal Splint				

G01	Amalgam-One Surface				
G02	Amalgam-Two+Surfaces				
G03	Amalgam-Three+Surfaces				
G21	Composite Anterior-One Surface				
G22	Composite Anterior-Two+Surfaces				
H01	Upper & Lower Anterior (1 root)				
H02	Upper Premolar (2 roots)				
H03	Lower Premolar (1 root)				
H04	Molars (3 + roots)				
L01	Single				
L02	Per additional tooth				
N11	Post Operative Care				

CODE	TREATMENT	NO OF UNITS	TOOTH NUMBER	DATE OF TREATMENT	CHARGE TO PATIENT
E21	Prolonged (Curettage/Root Planing)				
F51	Splinting				
F01	Gingivectomy				
F11	Mucoperio, Flap Bone Surgery				
R63	Additional Tooth				
R61	Addition of Clasp				
K71	Denture Repair				
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				
K02	Precious				
K01	Non Precious				
K03	Porcelain				

Total

Please return your completed claim form to:

Cigna
1 Knowe Road
Greenock
PA15 4RJ, Scotland

Tel: +44 1475 551441
Fax: +44 1475 492424
E-mail Address: iceasia@cigna.com

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