U.S. Dollar Wire Transfers & Non-U.S. Currency Claim Payment Request

Aetna Global Benefits®
Coverage underwritten by Aetna Life Insurance Company and Aetna Life & Casualty (Bermuda) Ltd.

Provider Payment Authorization

This form is required to establish a Provider election for claim payment via a U.S. Dollar wire transfer or in a Non-U.S. currency.

Aetna Global Benefits (AGB) can pay benefits to Providers via U.S. Dollar wire transfers or in your choice of over 100 Non-U.S. currencies through an arrangement with Citibank, N.A.. (New York). The currencies are classified as primary, secondary or tertiary and these classifications will change from time to time without notice.

Non-U.S. currency payments can be issued via a Check or Wire, depending on the currency classification. You may specify your preferred mode of payment on this form; however, AGB and Citibank, N.A.. (New York) reserve the right to issue the benefit payment in the mode of payment which is available for the currency type, as circumstances require.

Instructions Refer to this page when completing the attached form.	• Please print legibly and complete all of the items on this form to establish/modify a recurring reimbursement election. • We cannot and will not process forms with missing, illegible or inaccurate information. • In the event of an incomplete or illegible form, benefit payments will be made via a check in U.S. dollars. • **Return this completed form to Aetna Global Provider Services via Fax 1-860-975-0240 or email at AGBProviderServices@aetna.com.**
Provider Information	1. **Provider Name:** Enter the full name of the Provider. 2. **Contact Name:** Enter the name of the person in the Provider's business who should be contacted regarding wire transfers or check payments. 3. **Contact Telephone Number:** Enter the telephone number for the Contact identified in Number 2. 4. **Contact Fax Number:** Enter the fax number for the Contact identified in Number 2. 5. **Provider's Address:** Enter the Provider's mailing address.
Bank Information Contact your bank to complete and confirm the information in this section.	6. **Bank Name:** Enter the name of the bank or financial institution into which benefit payment(s) will be deposited. You shall notify AGB in writing of any changes to this information. Please be aware that it is the Provider's responsibility to appropriately communicate these changes, as the Provider will be responsible for any non-returned benefit payments distributed to your erroneously indicated account. 7. **Bank Identification Code:** Enter the bank "ID Code" (Routing Number) by which the bank can be identified for funds transfers. Providers should contact their bank(s) to verify this number. Please indicate if this code is a S.W.I.F.T./BIC, CHIPS UID, Federal ABA or Bank Sort identification code. 8. **Bank Account Number:** Enter the bank account number into which benefit payments should be transferred. 9. **Bank Accountholder's Name:** Enter the name of the bank accountholder into which benefit payments should be transferred. Enter this name as it appears on the Banking Statement. 10. **Bank Address:** Provide the phone number and address of the bank into which benefit payments are being deposited.
Intermediary Bank Information Contact your bank to complete and confirm the information in this section.	11. **Intermediary Bank Name:** Enter the name of the correspondent bank or financial institution branch that is located in the "country of currency" in the event a non-local currency wire transfer is being requested into your local bank account (Example: You are requesting Swedish Krona be wired into your Krona account located in the U.K.) 12. **Intermediary Bank Identification Code:** Enter the intermediary bank's "ID Code" (Routing Number) by which the bank can be identified for funds transfers. Providers should contact their bank(s) to verify this number. Please indicate if this code is a S.W.I.F.T./BIC, CHIPS UID, Federal ABA or Bank Sort identification code. 13. **Intermediary Bank Address:** Enter the address and phone number of the correspondent bank or financial institution branch that is located in the "country of currency".
Payment Information	14. **Payment Method:** Check the box that indicates your preferred method of payment.
Authorization	15. **Authorization:** Both the Provider's and the Bank Accountholder's (if different than the Provider) signature(s) and date(s) are required to authorize U.S. Dollar Wires and Non-U.S. Currency Claim payments.

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Provider Information	Bank Information	Intermediary Bank Information*
1. Provider Name	6. Bank Name	11. Intermediary Bank Name
2. Contact Name	7a. Bank Identification Code	12a. Bank Identification Code
3. Contact Telephone Number	7b. Bank ID Code Type: ☐ S.W.I.F.T./BIC ☐ CHIPS UID ☐ Federal ABA ☐ Bank Sort ID	12b. Intermediary Bank ID Code Type: ☐ S.W.I.F.T./BIC ☐ CHIPS UID ☐ Federal ABA ☐ Bank Sort ID
4. Contact Fax Number	8. Bank Account Number	13a. Intermediary Bank Street Address
5. Provider Street Address	9. Bank Account Holder's Name (Exactly as it is listed with the Bank.)	13b. Intermediary Bank City
5a. Provider City Address	10a. Bank Street Address	13c. Intermediary Bank State / Province / Country
5b. Provider Province / Country	10b. Bank City	13d. Intermediary Bank Zip / Postal Code
5c Provider Postal Code	10c. Bank State / Province / Country	13e. Intermediary Bank Telephone (Including Country Code)
5d Provider Email Address	10d. Bank Zip / Postal Code	*Required if non-local currency wire payments are requested for transfer into a local bank.
	10e. Bank Phone Number (Including Country Code)	

14. Payment Information

Check the box that indicates your preferred method of payment. If other than a U.S. Dollar wire, indicate the currency in which reimbursement is desired.

☐ Wire U.S. Dollars
☐ Wire Cayman Dollars

15. Authorization (Signature and Date Required)

I, _____ (Provider's Name) hereby authorize Aetna Life & Casualty (Bermuda), Ltd., Aetna Life Insurance Company, and any of their affiliated companies ("Aetna") and/or its 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 above.

I agree to notify Aetna in writing of any change relating to the information provided on this form or of a 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 unearned payments, I will be personally liable for all costs of collection. These costs include reasonable attorney's fees, incurred by Aetna and/or its dedicated Agents in the collection of such payments, together with the maximum interest or charges permitted by law.

In the case of any overpayment of benefits to my account, I agree that Aetna may debit my account for such overpayment, without further authorization from me. I also acknowledge my responsibility to notify AGB in writing of any changes in the information indicated above.

Employee's Signature (Include Bank Accountholder's Signature if Different than the Employee)	Date

Please Retain A Copy For Your Records