EXECUTIVE HEALTHCARE SOLUTIONS

aetna®

Claim Form for Travel Treatment Reimbursements

How to complete this form

One form must be completed for each claimant, for each travel claim. Please complete clearly in BLOCK CAPITALS.

Sections 1 to 12 must be completed in full by the claimant or the main member/spouse on their behalf, if the claimant is a dependant under the age of 18.

For information on how to contact us please refer to the 'Where to send your claim' section on page 6

Section 1: Claimant details (for whom the claim is for)

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms Other: _____

Family name (surname): _____ First name(s): _____

Date of birth (dd/mm/yyyy): _____ Gender: ☐ Male ☐ Female

Member ID[1]: _____ Plan number: _____

Plan sponsor: _____

Section 2: Main member/spouse details (if completing the form on behalf of the claimant)

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms Other: _____

Family name (surname): _____ First name(s): _____

Date of birth (dd/mm/yyyy): _____ Gender: ☐ Male ☐ Female

Member ID[1]: _____ Plan number: _____

Plan Sponsor (if applicable): _____

Trip start date (dd/mm/yyyy): _____ Trip end date (dd/mm/yyyy): _____

[1] as shown on your Member ID Card.

Section 3: Contact details for this claim

Correspondence address: _____

Town: _____ Postcode: _____ Country: _____

Email

Daytime phone: _____ Evening phone: _____

If you are sending this claim to us through your Broker or Plan Sponsor, and you wish for your claims statement (EOB) to be sent directly to them, please tick the box applicable to you. Broker ☐ Plan Sponsor ☐

Section 4: Claim summary

Confirm what this claim is for: _____

Section 5: Declaration – the Declaration must be signed by the claimant or the main member/spouse if the claimant is a dependant under the age of 18

I declare that, to the best of my knowledge, all the information provided on this Claim form is truthful and correct. I understand that Aetna will rely on the information provided as such. I agree and accept that this declaration gives Aetna, and its appointed representatives, the right to request past, present, and future medical information in relation to this claim, or any other claim related to the member/covered individual, from any third party, including providers and medical practitioners. I declare and agree that personal information may be collected, held, disclosed, or transferred (worldwide) to any organisation within the Aetna group, its suppliers, providers and any affiliates.

Claimant/main member's/spouse's name & signature:	Date (dd/mm/yyyy)

Please read carefully the disclaimers at the end of the form.
Please retain a copy for your records.

Section 6: Medical expenses and repatriation

Did the claimant return to their home address on the intended date? ☐ Yes ☐ No

If 'No', when did they return (dd/mm/yyyy)? _____

Who accompanied the claimant? _____

Did the claimant call the 24-hour International Helpline? ☐ Yes ☐ No

What symptoms did the claimant have which needed treatment? _____

Confirm the medical condition or diagnosis if known: _____

Section 7: Loss of deposits, cancellation and curtailment

Date holiday booked (dd/mm/yyyy): _____

Please attach original booking invoice and conditions/cancellation invoice.

Date of scheduled departure (dd/mm/yyyy): _____ Time of scheduled departure: _____

Date of cancellation or curtailment (dd/mm/yyyy): _____

Reason for cancellation or curtailment: _____

Please attach original cancellation notice if applicable. If caused by illness, injury or death, Section 6 needs to be completed or attach relevant medical report/copy of death certificate.

If the sick or injured person is someone other than the claimant, provide the following information:

Name: _____

Relationship to the claimant: _____

Address: _____

Type of expenses claimed:	**Invoice amount (including currency):**
	Total:

Section 8: Travel delay/hijack

Length of delay/hijack, specify how many hours: _____ Date(s) (dd/mm/yyyy): _____

Departure point: _____ Flight number if relevant: _____

Public transport carrier: _____

Cause of delay: _____

Evidence (Irregularity Report) must be supplied by the provider of the public transport service to confirm the length and cause of the delay.

Section 9: Missed departure

Reason for missed departure: _____

Detail the expenses incurred: _____

Type of expenses claimed:	**Invoice amount (including currency):**
	Total:

Attach original receipts and provide evidence to support the reason you missed your departure.

Section 10: Loss/damage of money/delayed luggage

Date of loss (dd/mm/yyyy): _____ Time of loss: _____

Place of loss: _____

Circumstances in which loss or damage occurred: _____

Where and to whom did the loss or damage occur: _____

Please attach the original Irregularity Report or Police Report and complete the following information:

Contact name: _____

Address: _____

Date loss reported (dd/mm/yyyy): _____

Name of household contents insurer and policy number: _____

Address of household contents insurer: _____

Give details of items lost/replaced. Continue on a separate sheet if needed. You must attach the original receipts with your claim.

Item:	**Date of purchase (dd/mm/yyyy):**	**Place of purchase:**	**Method of payment:**	**Owner's initials:**	**Amount (including currency):**
					Total:

Give details of money lost or stolen:

Description (e.g. cash, traveller's cheques, etc.):	**Value taken on trip:**	**Amount lost (including currency):**
		Total:

Section 11: Loss of passport/travel documents

Give details of and reasons for expenses incurred and attach original receipts.

Type of expenses claimed:	**Value taken on trip:**	**Amount (including currency):**
		Total:

Section 12: Payment details

Who are we reimbursing?

☐ Claimant/Main member	☐ The provider	☐ Another person or entity
Please complete the rest of this section below to tell us how you would like to be paid.	*We can only pay them if their bank details are shown on the invoice. You don't need to fill in the rest of this section.*	*If they paid on your behalf:* Name: _____ Relationship you: _____ If they didn't pay on your behalf but you'd like us to pay them, please tell us the reason why you want us to pay them instead of you, and fill in payee details below.

How would you like to be paid?

☐ Using your current Recurring Reimbursement Election (RRE) information

No further information required

☐ 1. By bank transfer

Account holder name: _____

If the account holder name is different to the names given in Section 1 and 2, tell us their full address and Email. We will not be able to make the payment without this information:

Account holder address: _____

_____

_____

_____

Email

Bank name and address (including town/city and country): _____

_____

_____

_____

Postcode: _____ BIC/Swift code (must be completed): _____

Payment Currency: _____ Bank account currency: _____

Account number: _____ IBAN: _____

Sort code (for UK accounts): _____ Routing code: _____

ABA number (for transfers to U.S located banks): _____

☐ Mark here to use these details as your RRE

☐ 2. By foreign draft or cheque

Account holder name: _____

If the account holder name is different to the names given in Section 1 and 2, tell us their full address and Email. We will not be able to make the payment without this information:

Account holder address: _____

_____

_____

_____

Email

Payment Currency: _____

Please note that banks may not always accept foreign drafts in all currencies.

Section 13: Medical expenses and repatriation – must be completed by the medical practitioner/specialist/therapist

1. Contact and registration details

Nature of illness or injury or cause of death: _____

If injury, how did it happen? _____

If illness, has the claimant suffered from the condition before? ☐ Yes ☐ No

If 'Yes', please give the date of the first occurrence (dd/mm/yyyy): _____

Name of medical practitioner who treated the claimant while abroad: _____

Tax Identification Number (required for providers practising in the US): _____

Address of medical practitioner: _____

Town: _____ Postcode: _____ Country: _____

Phone: _____ Fax: _____

Email: _____

Date(s) of treatment (dd/mm/yyyy): _____

Was the claimant hospitalised? ☐ Yes ☐ No

If yes, please give admission date (dd/mm/yyyy): _____ Discharge date (dd/mm/yyyy): _____

Name and address of hospital: _____

_____

2. Declaration

I declare that to the best of my knowledge and belief the information I have given in the Medical section of this Claim form is full, true and complete.

Medical practitioner's/specialist's/therapist's signature: _____

Date (dd/mm/yyyy): _____ Practice stamp: _____

Section 14: Further Information

How to complete this form

- If you are personally seeking reimbursement, we will only issue payment to:
  - the claimant if they are 18 or over
  - the plan holder if the claimant is under 18 and is a dependant under the plan, or
  - the parent or legal guardian named as the primary member, if the claimant is under 18
- If you have a household contents insurance plan or policy that covers you for lost/damaged goods, we will need to know the details as it may affect the amount we pay in respect of your claim.
- Ensure that you are able to receive payment in the method and currency you have requested.
- We reserve the right to pass on any payment charges incurred by us for cancelling the original payment due to inaccurate information submitted to us.
- We will not be responsible for any payment shortfall due to exchange rate fluctuations and/or recipient bank service charges. Please contact your bank for further details.
- If you do not give us the sort code/routing code, BIC/ SWIFT code and/or IBAN number, you may incur additional bank charges and it will result in a delay in us paying your claim. You can find the payment information on your bank statement.
- Payment by foreign draft or cheque in certain currencies can result in long delays. These delays are beyond our control. We will not pay any bank charges incurred in encashing a foreign draft or cheque. We strongly recommend that, wherever possible, you choose to be reimbursed by bank transfer as this is the quickest and safest method of payment.
- We can make payment in most readily traded currencies and to most countries. In the event that we are unable to make payment in the currency or to the country you have specified, we will contact you to confirm an alternative currency. If you do not specify a payment currency, we will pay your claim in the base currency of your plan.
- Your bank may ask you to complete additional paperwork before they can release our payment to you. This may delay your receipt of the payment and is outside our control.
- Whenever coverage provided by any insurance policy is in violation of any US, UN or EU economic or trade sanctions, such coverage shall be null and void. For example, Aetna companies cannot pay for health care services provided in a country under sanction by the United States unless permitted under a written Office of Foreign Assets Control (OFAC) license. Learn more on the US Treasury's website at: www.treasury.gov/resource-center/sanctions
- We will process the claim if the invoices and receipts for the treatment costs incurred contain all of the following:
  - diagnosis of the medical condition treated
  - treatment date
  - type of treatment, and
  - the medical provider's official stamp

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Checklist

- By post/Fax - Have you included:
  - ☐ A fully completed Claim form with signed and dated declarations
  - ☐ Original itemised invoices

  Photocopies, receipts and credit card statements are not acceptable. We are unable to return original documents, but are happy to provide certified copies on request.
  - ☐ An original Irregularity Report from the airline and/or Police Report if you are claiming under sections 8-11?
- By email:
  - ☐ Have you followed the scanned claims acceptance criteria and included any documents as required?

You will find the criteria for accepting scanned claims in your Claims procedures.

Send your claim to

- By post:

  Executive Healthcare Solutions
  6th Floor, 9 West
  Ring Road Parklands
  PO Box 14680, 00800, Westlands
  Nairobi, Kenya
  Tel: +254 20 291 0000
  Email: claims@executive-healthcare.com

  Aetna Global Benefits Limited
  PO Box 6380
  Dubai

  United Arab Emirates
- Send your claim via fax attaching receipts and all required documents from your medical practitioner, as explained above, to: +254 20 291 0600
- Send your claim via email with copies of your reciepts and all required documents from your medical practitioner, as explained above, to: claims@executive-healthcare.com
- For claim related queries please contact us on: +254 20 291 0000

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