

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: | | | | |
| Member ID ¹ : | Plan number: | | | |
| Plan sponsor: | | | | |
| Section 2: Main member/spouse details (if completing | | | | |
| Title: Mr Mrs Miss Ms | Other: | | | |
| Family name (surname): | | | | |
| 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): | | | | |
| as shown on your Member ID Card. | | | | |
| Section 3: Contact details for this claim | | | | |
| Correspondence address: | | | | |
| Town: Postcode: | Country: | | | |
| Email | Email | | | |
| Daytime phone: | Evening phone: | | | |
| If you are sending this claim to us through your Broker or Plan Spor directly to them, please tick the box applicable to you. | nsor, and you wish for your claims statement (EOB) to be sent Broker Plan Sponsor | | | |
| Section 4: Claim summary | | | | |
| Confirm what this claim is for: | | | | |
| Section 5: Declaration – the Declaration must be signe claimant is a dependant under the age of 18 | d by the claimant or the main member/spouse if the | | | |
| I declare that, to the best of my knowledge, all the information provided harian National Life Assurance will rely on the information provided National Life Assurance, and its appointed representatives, the right relation to this claim, or any other claim related to the member/cove medical practitioners. I declare and agree that personal information any organisation within the Aetna group, its suppliers, providers and Claimant/main member's/spouse's name & signature: | d as such. I agree and accept that this declaration gives Bahrain to request past, present, and future medical information in red individual, from any third party, including providers and may be collected, held, disclosed, or transferred (worldwide) to | | | |
| Glaimanumain member s/spouse's hame & signature. | Date (dd/fiifi/yyyy) | | | |

| Section 6: Medical expenses and repatriati | on | | | |
|---|---|--|--|--|
| Did the claimant return to their home address on the i | intended date? | | | |
| If 'No', when did they return (dd/mm/yyyy)? | | | | |
| Who accompanied the claimant? | | | | |
| Did the claimant call the 24-hour International Helplin | e? ☐ 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 | · | | | |
| Date of scheduled departure (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 tha | n 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: | | | | |
| Public transport carrier: | | | | |
| | _ | | | |
| Cause of delay: | | | | |
| Evidence (Irregularity Report) must be supplied by the delay. | provider of the public transport service to confirm the length and cause of the | | | |
| 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.

| Date of loss (dd/mm | n/yyyy): | | Time of loss: | | |
|---|-----------------------------------|-----------------------|--------------------------|-----------------------------------|------------------------------|
| • | "yyyy) | | - | | |
| | | | | | |
| | | | | | |
| | | | and complete the follow | | |
| | | _ | • | _ | |
| | | | | | |
| | | | | | |
| Name of household | contents insurer and pol | icy number: | | | |
| Address of househo | old contents insurer: | | | | |
| Give details of item | s lost/replaced. Continu | e on a separate sheet | if needed. You must atta | ch the original recei | pts 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 mo | ney lost or stolen: | | | | l |
| Description (e.g. cash, traveller's cheques, etc.): | | Value taken on trip: | | Amount lost (including currency): | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | <u> </u> | | Total: |
| | | | | | |
| | oss of passport/trave | | | | |
| | I reasons for expenses | incurred and attach | <u>-</u> | | T - |
| Type of expenses claimed: | | Value taken on trip: | | Amount (including currency): | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | 1 | | 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 Reimburser | ment Election (RRE) information | | | | |
| No further information required | | | | | |
| ☐ 1. By bank transfer | | | | | |
| Account holder name: | | | | | |
| | e names given in Section 1 and 2, tell us their | | | | |
| | | | | | |
| · | | | | | |
| | | | | | |
| | | | | | |
| 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 ba Mark here to use these details as your F | , | | | | |
| 2. By foreign draft or cheque | NE . | | | | |
| | | | | | |
| Account holder name: | e names given in Section 1 and 2, tell us their | full address and Email Mo will not be able | | | |
| to make the payment without this information | | full address and Email. We will not be able | | | |
| 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 deat | h: | | | | | | | |
| If injury, how did it happen? | | | | | | | | |
| If illness, has the claimant suffered from the | | | | | | | | |
| If 'Yes', please give the date of the first or | | | | | | | | |
| Name of medical practitioner who treated | the claimant while abroad: | | | | | | | |
| Tax Identification Number (required for pro | oviders practising in the US | S): | | | | | | |
| Address of medical practitioner: | | | | | | | | |
| Town: | Postcode: | | Country: | | | | | |
| Phone: | | Fax: | | | | | | |
| Email: | | | | | | Ш | | |
| Date(s) of treatment (dd/mm/yyyy): | | | | | | | | |
| Was the claimant hospitalised? | □ 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 true and complete. | and belief the information | I have given i | in the Medical sec | tion of th | is Clair | n form | is fu | ıll, |
| Medical practitioner's/specialist's/therapis | t's signature: | | | | | | | |
| Date (dd/mm/yyyy): | Practice stam | p: | | | | | | |

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

| Check | 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 wi | ill find the criteria for accepting scanned claims in your Claims procedures. | | | | | |

Where to send your claim

Send us your claim in one of the ways listed below:

- By email to: MEAServices@aetna.com
- By fax to: +971-4-428-7101
- By post to: Aetna Global Benefits Limited Emirates Financial Tower, 17th Floor, North Tower DIFC, PO Box 6380, Dubai, United Arab Emirates

We know you may have questions and we're always here to help. You can call us any time on:

Phone: +800-81429 (Free form Kingdom of Bahrain)

+44-203-788-3293 (Collect or Direct)

Aetna® is a trademark of Aetna Inc. and is protected throughout the world by trademark registrations and treaties.

BNL and Aetna do not provide care or guarantee access to health services. Not all health services are covered, and coverage is subject to applicable laws and regulations, including economic and trade sanctions. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a health care professional. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Information is believed to be accurate as of the production date; however, it is subject to change. For more information, refer to www.AetnaInternational.com.

If coverage provided by this policy violates or will violate any United States (US), United Nations (UN), European Union (EU) or other applicable economic or trade sanctions, the coverage is immediately considered invalid. For example, BNL and Aetna companies cannot make payments or reimburse for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or entity, or a country under sanction by the US, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information on OFAC, visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Policies are underwritten by Bahrain National Life Assurance BSC. All claims and claims related activity occurring outside of Bahrain will be administered by Aetna Global Benefits Limited - a company regulated by the DFSA. Registered address: Emirates Financial Tower, 1701 - F, 17th Floor, North Tower, DIFC, PO Box 6380, Dubai, UAE.

Important: This is a non-US insurance product that does not comply with the US Patient Protection and Affordable Care Act (PPACA). This product may not qualify as minimum essential coverage (MEC), and therefore may not satisfy the requirements, if applicable to you and your dependants, of the Individual Shared Responsibility Provision (individual mandate) of PPACA. Failure to maintain MEC can result in US tax exposure. You may wish to consult with your legal, tax or other professional advisor for further information. This is only applicable to certain eligible US taxpayers.