



Claim Form for Maternity Treatment Reimbursements

For the quickest way of submitting your claim, log into Health Hub at www.aetnainternational.com and submit your claim online.

How to complete this form

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

Sections 1 to 7 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.

Section 8 must be completed by the medical practitioner, specialist or therapist if required.

Assessment of the claim may be delayed if all the necessary sections of this form are not completed.

We may need to contact the claimant's medical practitioner, specialist or therapist for more medical information in order for us to process the claim under the terms and conditions of the policy. We will tell you if we need to do this.

For information on how to contact us please refer to the 'Where to send your claim' section on page 5.

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

Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Other: _____
Family name (surname): _____	First name(s): _____
Date of birth (dd/mm/yyyy): _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Member ID ¹ : _____	Plan number: _____
Plan sponsor: _____	

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

Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Other: _____
Family name (surname): _____	First name(s): _____
Date of birth (dd/mm/yyyy): _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Member ID ¹ : _____	Plan number: _____
Plan sponsor (if applicable): _____	

¹ as shown on your Member ID Card.

Section 3: Contact details for this claim

Correspondence address: _____																																	
Town: _____	Postcode: _____ Country: _____																																
Email <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td> </tr> </table>																																	
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 <input type="checkbox"/> Plan Sponsor <input type="checkbox"/>																																	

Section 4: Claim summary

Is this a new claim? <input type="checkbox"/> Yes <input type="checkbox"/> No	If 'Yes', complete the following and refer to 'How to complete this form' for further advice.
What symptoms did the claimant have which needed treatment? _____	

Confirm the medical condition or diagnosis if known: _____	

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: Claim details

Is this claim for a repeat antenatal checkup? <input type="checkbox"/> Yes <input type="checkbox"/> No	If 'Yes', Section 8 does not need to be completed. If 'No' and this is a new claim or a claim for treatment costs for complications during pregnancy, Section 8 needs to be completed by the medical practitioner or specialist.
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Is this a claim for hospital cash benefit? <input type="checkbox"/> Yes <input type="checkbox"/> No

If 'Yes', Section 8 must be completed by the medical practitioner or specialist. Once completed, please send us the original admission and discharge form from the hospital where the treatment was provided together with this Claim form.

If 'No', provide the breakdown of the invoices being submitted with this claim:

Country of treatment	Date of treatment (dd/mm/yyyy)	Invoice date (dd/mm/yyyy)	Invoice reference	Invoice amount (including currency)

Use a separate sheet if you need more space.	Total number of invoices:
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Does the claimant have another insurance plan or policy that covers medical maternity costs? <input type="checkbox"/> Yes <input type="checkbox"/> No

If 'Yes', provide the other insurer's details including the name of the insurer, the insurer's address and the claimant's plan or policy number with that insurer: _____

Section 7: Payment details

Who are we reimbursing?		
<input type="checkbox"/> Claimant/Main member	<input type="checkbox"/> The provider	<input type="checkbox"/> Another person or entity
<p><i>Please complete the rest of this section below to tell us how you would like to be paid.</i></p>	<p><i>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.</i></p>	<p><i>If they paid on your behalf:</i> Name: _____ Relationship you: _____</p> <p><i>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.</i></p>

How would you like to be paid?	
<input type="checkbox"/> Using your current Recurring Reimbursement Election (RRE) information <i>No further information required</i>	
<input type="checkbox"/> 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: [Grid] _____ 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): _____ <input type="checkbox"/> Mark here to use these details as your RRE	
<input type="checkbox"/> 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: [Grid] _____ Payment Currency: _____ Please note that banks may not always accept foreign drafts in all currencies.	

Section 9: 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 planholder 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
- 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 this 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

What to send us

Send us the claim within 180 days of the first treatment date. You must send the following items to make sure that we can process your claim:

- the fully completed Claim form
- the original itemised invoice
- the original receipt. We do not accept credit card statements as proof of payment
- a copy of the prescription if you are claiming for medication
- a copy of the investigative tests results if relevant (e.g. blood tests, x-rays, ultrasound, etc.)
- a copy of the physiotherapy or complementary medicine referral by the medical practitioner or specialist if applicable, and
- a copy of the admission and discharge reports for inpatient or daycare admissions.

Where to send your claim

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

- By logging in to your Health Hub at www.aetnainternational.com and submitting your claim online.
- By email to: AsiaPacServices@aetna.com.
- By post to: Aetna Global Benefits Limited (Singapore Branch), 80 Robinson Road, #23-02/03, Singapore 068898

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

Phone: 1-800-723-1241 (Free from Singapore)
+65-6701-6912 (Collect or Direct)

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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.

Please read carefully the disclaimers at the end of the form.

Please retain a copy for your records.