Global Health Benefits

Medical Benefits Abroad

Cigna Health and Life Insurance Company
Connecticut General Life Insurance Company

Mailing Address: P.O. Box 15111
Wilmington, DE 19850 USA

Eligibility Verification Form

In order for your health claim to be considered for reimbursement, you and your employer must complete and sign this Eligibility Verification statement certifying that you are an eligible employee on an approved international business trip. Please return this completed statement, the MBA Claim Form and all original documentation/receipts from the treating doctor or hospital, including the date of treatment, the diagnosis and pertinent charges to Cigna at:

Cigna
Attn: Eligibility Unit
P.O. Box 15111
Wilmington, DE 19850-5111

Phone: (800) 243-1348 (US and Canada only)
Fax: (302) 797-3150
Website: www.CignaEnvoy.com

Section A. Employee Information

Name: Account Number:

Date of Birth: Country of Permanent Residence:

Home Address:

Home Phone: Business Phone:

Dates of Travel (*required*): Departure: Return:

Countries Traveled to (*list all*):

The purpose of my international travel was:

Dependent Information (Eligible only if accompanying the employee as described in your policy.)

This claim is for an eligible dependent: ☐ Yes ☐ No

Dependent's Name: Dependent's Date of birth:

Dependent's Country of Permanent Residence:

Relationship to employee:

I certify that I am an employee and that the health expenses for which I am submitting reimbursement were incurred in the treatment of an accident or illness while on approved international business travel. If the claim that I am submitting is on behalf of a dependent, I certify that my dependent meets the definition of an eligible dependent as described in my policy.

Employee Signature:_____ **Date:**

Section B. Employer Information

Name: Account Number:

Company Name and Address:

We certify that the employee named above is an eligible employee of our company and that the employee was on approved business travel

From: To: At the following locations:

Employer Signature:_____ **Date:**

FRAUD NOTICE: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.