



AGB WorldTravelerSM Claim Form

Aetna Global Benefits®

Please also complete Page 2 of this form.

Medical Pharmacy

Please mail or fax completed Claim Form with itemized bills and receipts. A separate Claim Form is needed for each family member. Please tape small receipts on a full size sheet of paper.

Aetna Global Benefits P.O. Box 30258 Tampa, FL 33630-3258 USA	OR	Aetna Global Benefits 4630 Woodland Corporate Blvd. Tampa, FL 33614 USA	Telephone: +1-877-301-5042 (outside the USA, via AT&T + access) +1-813-775-0190 (direct or collect outside the USA)
			Facsimile: +1-800-475-8751 (outside the USA, via AT&T + access) +1-813-775-0625 (inside the USA)
			E-mail: agbservice@aetna.com

1. Employee Information

Employer Name/Group Number _____
 Employee's Name _____
(First Name, Middle Initial, Last Name/Surname)

Identification Number _____
(Aetna assigned upon receipt of initial claim, or refer to the Explanation of Benefits (EOBs) from previous AGB WorldTraveler claim submissions.)

Employee's Birthdate (mm/dd/yyyy) _____ Gender Male Female

Street _____
 City _____ State/Province _____
 Country _____ Postal/Zip Code _____

Employee's Telephone Number (Include Country Code) _____
 Employee's Primary E-Mail Address _____
(Email addresses are strongly encouraged in the event additional information is needed to process your claim.)

2. Patient Information

Patient's Name (First Name, Middle Initial, Last Name/Surname) _____
 Relationship: Self Spouse Child Other _____
 Patient's Birthdate (mm/dd/yyyy) _____ Gender Male Female

3. Other Health Coverage/Scheme

Are any family members' expenses covered by another health plan/scheme, Medicare, or any U.S. Federal, U.S. State, National, Social government plan?
 Yes No If "Yes," please complete information below.

Name and Relationship of the Family Member _____
(First Name, Middle Initial, Last Name/Surname)

Family Members Birthdate (mm/dd/yyyy) _____ Gender Male Female

Name of other Insurance Company or Type of Insurance _____

4. Summary of Medical and Pharmacy Services (Please include diagnosis or reason for treatment for each service received.)

Dates of Service (mm/dd/yyyy)	Provider's (physician, clinic, hospital, pharmacy) Name and Address (If the Provider's name and address is on receipts, write "see receipts")	Description of Service/ Name of Medication/ Drug/Device (If hospital, indicate inpatient or outpatient)	Diagnosis (Reason for visit)	City/State/ Province/Country of Claim	Currency of Claim	Total Charge

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Employee's Name _____
(First Name, Middle Initial, Last Name/Surname)

5. Claim Information

If Yes is answered to either question below, **c** and **d** in this section must be completed.

- a. Is the claim related to a work related accident or condition? Yes No
- b. Is the claim related to an accidental injury? Yes No
- c. Accident Date (mm/dd/yyyy)

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 Time _____ AM PM
- d. Description of Accident (How and Where)

6. Summary of Reimbursement – Only one requested method of reimbursement and currency will be honored per claim form request. (Unless otherwise indicated, reimbursements will be made payable to the party to which the payment is sent and will be issued via US\$ checks.)

Send Payment To: Employee Provider

Requested Reimbursement Method:

Method	Country/Currency Type for Reimbursement (i.e., Great Britain / Pounds)																					
<input type="checkbox"/> Wire																						
<input type="checkbox"/> Check																						
<input type="checkbox"/> Electronic Funds Transfer (EFT)	Available as follows: <table style="width: 100%; border: none;"><tr><td><input type="checkbox"/> Australia – AUD (Dollar)</td><td><input type="checkbox"/> Germany – Euro</td><td><input type="checkbox"/> New Zealand – NZD (Dollar)</td></tr><tr><td><input type="checkbox"/> Austria – Euro</td><td><input type="checkbox"/> Great Britain - GBP (Pound)</td><td><input type="checkbox"/> Norway - NOK (Krone)</td></tr><tr><td><input type="checkbox"/> Belgium – Euro</td><td><input type="checkbox"/> Greece – Euro</td><td><input type="checkbox"/> Portugal – Euro</td></tr><tr><td><input type="checkbox"/> Canada - CAD (Dollar)</td><td><input type="checkbox"/> Hong Kong – HKD (Dollar)</td><td><input type="checkbox"/> Singapore SGD (Dollar)</td></tr><tr><td><input type="checkbox"/> Denmark - DKK (Krone)</td><td><input type="checkbox"/> Ireland – Euro</td><td><input type="checkbox"/> Spain – Euro</td></tr><tr><td><input type="checkbox"/> Finland – Euro</td><td><input type="checkbox"/> Italy – Euro</td><td><input type="checkbox"/> Sweden - SEK (Krona)</td></tr><tr><td><input type="checkbox"/> France – Euro</td><td><input type="checkbox"/> Netherlands – Euro</td><td><input type="checkbox"/> United States - US\$ (Dollar)</td></tr></table>	<input type="checkbox"/> Australia – AUD (Dollar)	<input type="checkbox"/> Germany – Euro	<input type="checkbox"/> New Zealand – NZD (Dollar)	<input type="checkbox"/> Austria – Euro	<input type="checkbox"/> Great Britain - GBP (Pound)	<input type="checkbox"/> Norway - NOK (Krone)	<input type="checkbox"/> Belgium – Euro	<input type="checkbox"/> Greece – Euro	<input type="checkbox"/> Portugal – Euro	<input type="checkbox"/> Canada - CAD (Dollar)	<input type="checkbox"/> Hong Kong – HKD (Dollar)	<input type="checkbox"/> Singapore SGD (Dollar)	<input type="checkbox"/> Denmark - DKK (Krone)	<input type="checkbox"/> Ireland – Euro	<input type="checkbox"/> Spain – Euro	<input type="checkbox"/> Finland – Euro	<input type="checkbox"/> Italy – Euro	<input type="checkbox"/> Sweden - SEK (Krona)	<input type="checkbox"/> France – Euro	<input type="checkbox"/> Netherlands – Euro	<input type="checkbox"/> United States - US\$ (Dollar)
<input type="checkbox"/> Australia – AUD (Dollar)	<input type="checkbox"/> Germany – Euro	<input type="checkbox"/> New Zealand – NZD (Dollar)																				
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<input type="checkbox"/> Finland – Euro	<input type="checkbox"/> Italy – Euro	<input type="checkbox"/> Sweden - SEK (Krona)																				
<input type="checkbox"/> France – Euro	<input type="checkbox"/> Netherlands – Euro	<input type="checkbox"/> United States - US\$ (Dollar)																				

If you elected to be reimbursed in a U.S. dollar check, skip to **Section 8**. All other reimbursement methods, continue with **Sections 6 and 7**.

Please check one of the following (as applicable):

- Use the Recurring Reimbursement Election (RRE) information currently on file.
- Use the banking information provided in **Section 7** below and the Reimbursement information provided above to establish an RRE.
- Update the current RRE information on file with the information provided in **Section 6** above and/or **Section 7** below.
- Use the banking information provided in **Section 7** below and the Reimbursement information provided above only for this Benefit Request.

7. Bank Information (Bank information can be obtained by contacting your banking institution.)

Primary Bank – Required if wire transfer or EFT, as available, is your preferred reimbursement method as specified in Section 6. (AGB can wire or EFT reimbursements to your bank at no cost. However, we encourage you to check with your bank to determine the fee your bank may charge you for these transaction(s).)

Bank Information is for: Employee Provider

Bank Name _____

Bank Identification Code/Routing Number _____ Bank ID Code Type _____

S.W.I.F.T./BIC Code CHIPS UID Federal ABA Bank Sort ID IBAN Bank Account Number _____

Name of Accountholder (As it appears on the Bank Statement) _____

Bank Address (Include Country) _____

Bank Telephone Number (Include Country Code) _____

8. Authorization (Required)

For All Electronic Deposits: I hereby authorize Aetna Life & Casualty (Bermuda) Ltd., Aetna Life Insurance Company, and any of their affiliated companies ("Aetna") and/or their 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 on this form. I agree to notify Aetna in writing of any changes relating to the information provided on this form or 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 payments, I will personally be liable for all costs of collection (including reasonable attorney's fees and the maximum interest permitted by law.)

Medical and Pharmacy Authorization. Must be signed and Dated: I authorize all physicians, other health professionals, pharmacies/pharmacists, hospitals and health care institutions to provide Aetna and any independent parties acting on Aetna's behalf or with whom Aetna has contracted, information concerning health care, advice, treatment or supplies provided to the Patient (including that related to mental illness and/or AIDS/ARC/HIV). This information will be used for the purposes of evaluating and administering claims. Aetna may provide the employer named on this form with any benefit calculation used in the payment of this claim for the purpose of reviewing the experience and operation of the policy/contract. This authorization is valid for the term of the policy or contract under which a claim is submitted. I know I have a right to receive a copy of this authorization upon request and agree that a copy of this authorization is as valid as the original.

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant.

Patient's or Authorized Person's Signature _____ Date (mm/dd/yyyy) _____

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