



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

**5. 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 Currency Type for Reimbursement: \_\_\_\_\_

Requested Reimbursement Method:  Wire  Check

If you elected to be reimbursed in an U.S. dollar check, skip to **Section 7**. All other reimbursement methods, continue with **Sections 5 and 6**.

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 6** below and the Reimbursement information provided above to establish an RRE.
- Update the current RRE information on file with the information provided in **Section 5** above and/or **Section 6** below.
- Use the banking information provided in **Section 6** below and the Reimbursement information provided above only for this Benefit Request.

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

**a. Primary Bank – Required if wire transfer is your preferred reimbursement method as specified in Section 5.**  
(AGB can wire 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 this transaction.)

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 Bank Account Number \_\_\_\_\_

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

Bank Address (Include Country) \_\_\_\_\_

Bank Telephone Number (Include Country Code) \_\_\_\_\_

**b. Intermediary Bank – Required if Section 5 is completed AND non-local currency wire payments are requested into your local bank.**

Intermediary Bank Name \_\_\_\_\_

Intermediary Bank Identification Code/Routing Number \_\_\_\_\_ Intermediary Bank ID Code Type \_\_\_\_\_

S.W.I.F.T./BIC Code  CHIPS UID  Federal ABA  Bank Sort ID Intermediary Bank Account Number \_\_\_\_\_

Intermediary Bank Address (Include Country) \_\_\_\_\_

Intermediary Bank Telephone Number (Include Country Code) \_\_\_\_\_

**7. 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 \_\_\_\_\_

**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, Dental, Vision Authorization. Must be signed and Dated:** I authorize all physicians, other health professionals, 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, advise, 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 names 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) \_\_\_\_\_

**Please Retain A Copy For Your Records**