

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

5. Summary of Reimbursement - Your Aetna plan of benefits includes the option of claim reimbursements in a variety of currencies and disbursement methods. Establish your selected option in the sections below. We reserve the right to issue the benefit reimbursement in the mode of payment available for the currency type, as circumstances dictate.

If you elect to be reimbursed in a U.S. dollar check, skip to **Section 8**. All other reimbursement methods continue with **Sections 5, 6** and **7**. Please check one of the following (as applicable) - if left unchecked we will observe for this claim submission only:

- Use the Recurring Reimbursement Election (RRE) information currently on file.
 Use the information provided in **Sections 5** and/or **6** to establish an RRE.
 Update the current RRE information on file with the information provided in **Sections 5** and/or **6**.
 Use the information provided in **Sections 5** and/or **6** only for expenses related to this claim form.

Summary of Reimbursement (Method/Currency Type) – Only one method of reimbursement and currency will be honored per claim form. (Unless otherwise indicated, reimbursements will be made via US\$ check and payable to the party to which payment is sent.)

Use the information provided below to send any applicable reimbursement payment to: Employee Provider

| Requested Reimbursement Method | Country/Currency Type for Reimbursement (i.e., Great Britain / Pounds) If the currency you have elected is not available for the method requested, we will default reimbursement to US\$. |
|--|--|
| <input type="checkbox"/> Funds Transfer (Preferred) The most efficient method of receiving your benefits reimbursement is via Funds Transfer. Please check with your bank for help with providing the appropriate instructions to Aetna. | |
| <input type="checkbox"/> Check | (Complete the Country/Currency and go to Section 8 .) |

6. Bank Information

Primary Bank –The following information is required if you have elected Funds Transfer as your preferred method for reimbursements. We will transfer funds to your bank at no cost to you; however, we encourage you to check with your bank to determine any additional fees your bank may charge you for receiving Funds Transfer(s).

Bank Account Number _____
 Name of Accountholder (As it appears on the Bank Statement) _____
 Bank Identification Code/Routing Number _____
 S.W.I.F.T./BIC Code (wire only) CHIPS UID Federal ABA Bank Sort ID IBAN Other _____
 Bank Name _____
 Bank Address (Include Country) _____
 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, or 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 Member's 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, Pharmacy, Dental, and Vision 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.

You may elect to use an electronic form of signature on this claim form confirming your verification and declaration to the details given above. For the avoidance of doubt such electronic signature will be valid and binding as if you had provided your original signature. We may rely on such electronic signature as a binding verification and declaration confirming that the information above is accurate and not misleading in all respects.

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

Please Retain A Copy For Your Records