

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
 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: <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)

If you elected to be reimbursed in a 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.)

Primary Bank – Required if wire transfer or EFT, as available, is your preferred reimbursement method as specified in Section 5.
 (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) _____

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