Claim Form

Talent Trust

Please submit this completed claim form with itemized bills, receipts and prescriptions. A separate claim form is needed for each family member. Failure to complete all sections of this form may result in claim processing delays. A separate claim form must be completed for each condition claimed. Important Note: Please ensure your claim form is completed in full and returned within 90 days of the treatment date.									
Main Insured Name					Member ID /	Cert. Num			
Mailing Address									
*Compulsory									
Postcode			State				Country		
Patient's Details •com	pulsory								
Patient's name					Member ID /	Cert. Num			
Gender	Male	Female	9						
Birth Date	day	month	year		Email				
Telephone					Mobile				
Other Health Insura	nce Cove	erage							
Do you hold any other insu			Yes (If yes please comp	olete)	Other carrier	Name			
Other Insurance Policy Nu		110		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Policy Holder				
					1 only 1 ondo	Numo			
Claims Information									
	-		ould include a prescriptio homeopath treatment, a	-	-		cialist. ır treating doctor or a me	dical specialist.	
For dental claims, pla	ease indicate	the affected	tooth and ensure that an	itemized br	eakdown of servio	ces is included			
Date condition first present	ed. *Compute	sory da	y month	year					
Diagon tigk if this is part of									
Please lick if this is part of	an ongoing c	laim that you	have previously submitt	ed items for	*Compulsory	No	Yes		
For maternity claims, pleas	e indicate the	-		ted items for	*Compulsory	No year	Yes		
For maternity claims, pleas *Compulsory to fill the following det Date of pharmacy Services (If name	e indicate the alls s (physician, v, dentist) nar and address	e expected du clinic, hospita me and addre is on receipt	ue date of your baby al, Description of Ser ss of medication/ D hospital, state Inp	day vice/Name Device (If atient, Day		year	Yes Country of Claim	*Below table is con Currency of Claim	^{mpulsory} to be filled. Total Charge
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Payment Information

Recurring Reimbursement Election - Please check one of the following options if you want to					
Receive future payments using the details provided below					
Use the payment information provided below for this claim only					
Use the payment details that we already have on file for you					
Please select your preferred reimbursement method Compulsory Bank Transfer Check (default)					
Please indicate your preferred payment currency (if none is selected the default currency is US Dollar)					
Payee Name					
Address to where check to be sent <i>(include Country)</i> Note: Do not use P.O.Box address. Please provide Contact Person's name and Telephone number.					
If you have selected Bank Transfer, the following information is required - Note: Different countries require different information, please provide as much as you have available.					
Account Holder Name Bank Name					
IBAN code					
Bank Account number					
Bank Address					
Prayer Needs					
If you have an ongoing condition and would like this to be shared by TTc as a prayer need, please tick this box Yes No					
Prayer Requests					
Declaration					

I declare that to the best of my knowledge, all the information provided on this claim form is truthful and correct. I understand that Aetna will rely on the information provided as such. I agree and accept that this declaration gives Aetna, and its appointed representatives, including Talent Trust Consultants, the right to request past, present, and future medical information in relation to this claim, or any other claim related to the member/covered individual, from any third party, including providers and medical practitioners. I declare and agree that personal information may be collected, held, disclosed, or transferred *(worldwide)* to any organization within the Aetna group, its suppliers, providers and any affiliates, including Talent Trust Consultants.

Patient's Signature (If patient is under 18 years of age, Parent or Guardian must sign).	*Compulsory	Date	day	month	year
Additional information					

How to submit your claim

For details on procedures to submit claims, please refer to:	http://www.talent-trust.com/claims

Important Points:

- When scanning documents, please ensure that you use lower resolution to keep the file sizes small. Aetna's email system is unable to accept emails larger than 8Mb and will reject the email if the size exceeds the allowable limit.
- A separate claim form and all supporting documentation must be submitted for each medical condition and/or each claimant.
- Submit complete set of claim documents fully completed claim form, bills from providers, receipts as proof of payment and relevant referral letter (*if applicable*) to claims@talent-trust.com
- For claims related query/follow-up, please contact our 24-hour Member Services helpline at +1 (877) 248 2197
- * Compulsory ensure these fields are filled.

Important Note - Failure to complete your form in full will result in the form being returned to you and will delay the processing of your claim. Please note Talent Trust Consultants/Aetna International is not responsible for any costs associated with the completion of your form or for any further information/documents requested by us to assess your claim. The issuing of this claim form is in no was an admission of liability.

www.talent-trust.com

Personal Details - Have you provided your name, mailing address, contact number and email address?

Patient Details - Have you provided the patient's name (if different from primary member), date of birth, member ID/ certificate number?

Claims Details - Have you provided the date symptoms started, date of service, medical diagnosis/reason for the visit and claim amount?

Payment Details - Have you provided your bank account details or mailing address for your claim reimbursement?

Declaration - Have you signed the claim form?

Claim Documents

Have you attached the medical bills/invoices for your medical treatment?

Have you attached the proof of payment for your medical expenses?

Have you attached a referral letter from the attending doctor for any physiotherapy, psychiatric treatment or other treatment requiring a referral (where applicable)?

Have you completed a separate claim for each medical condition?