Claim Form

Talent Trust Consultants

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 *Compulsory

Patient's name		Member ID / Cert. Num	
Gender	Male	Female	
Birth Date	day / month / year	Email	
Telephone		Mobile	

Other Health Insurance Coverage

Do you hold any other insurance?	No / Yes *(If yes please complete)*	Other carrier Name	
Other Insurance Policy Number		Policy Holder Name	

Claims Information

Please note:

- Claims for prescription drugs or medication should include a prescription from your treating doctor or a medical specialist.
- Acupuncture, podiatry, chiropractic, osteopath, homeopath treatment, and physiotherapy require a referral from your treating doctor or a medical specialist.
- For dental claims, please indicate the affected tooth and ensure that an itemized breakdown of services is included.

Date condition first presented. *Compulsory day / month / year

Please tick if this is part of an ongoing claim that you have previously submitted items for *Compulsory No / Yes

For maternity claims, please indicate the expected due date of your baby day / month / year

*Compulsory to fill the following details

*Below table is compulsory to be filled.

Date of Services (dd/mm/yyyy)	Provider's *(physician, clinic, hospital, pharmacy, dentist)* name and address *(If name and address is on receipts, write "see receipts")*	Description of Service/Name of medication/ Device *(If hospital, state Inpatient, Day Case or Outpatient)*	Diagnosis/Reason for visit	Country of Claim	Currency of Claim	Total Charge

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 *(include Country)*
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		SWIFT/Sort/BIC/Branch code	
Bank Account number		US ABA/FedWire 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.

Claim Form Checklist

- [ ] **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?