Recurring Reimbursement Election

Aetna International

Your Aetna International plan of benefits includes the option of claim reimbursements in a variety of currencies and disbursement methods, as available, through an arrangement with Citibank, N.A. (New York). This form is required to create or replace a recurring reimbursement election established to receive benefit reimbursements in a method/mode other than U.S. Dollar checks. Recurring reimbursement elections are for employees who are requesting that their and their covered dependents' ensuing claim payments be uniformly issued in the same currency, method, and, as applicable, to the same bank account or location.

Non-U.S. currency payments can be issued via a Check, Wire, or Electronic Funds Transfer (EFT), depending on the currency classification and recipient location. The currencies are classified as primary, secondary, or tertiary and these classifications will change from time to time without notice. You may specify your preferred mode of payment on this form; however, Aetna International and Citibank, N.A. (New York) reserve the right to issue the benefit payment in the mode of payment which is available for the currency type, as circumstances require.

Instructions - Refer to this page when completing the form.

- Please print legibly and complete all of the items on this form to establish/modify a recurring reimbursement election.
- We cannot and will not process forms with missing, illegible, or inaccurate information.
- In the event of an incomplete or illegible form, benefit payments will be made via a check in U.S. dollars.
- **Submit this completed form by AT&T Global Toll Free Fax to +1-877-287-1938 or direct 1-813-775-0195 or mail this completed form to:**
  Aetna International, PO Box 981543, El Paso, TX, 79998-1543, U.S.A.

Contract Information	1. **Group Control-Suffix-Account:** Include the Group Control, Suffix, and Account numbers for the Aetna International contract in which you and your dependents were enrolled in when the claim was incurred. (Refer to your ID Card for this GRP information.) 2. **Employee Name:** Enter the first name, middle initial and last name of the individual who will be receiving the claim reimbursement(s). **As used, herein, the term "Employee" shall be defined to include the Participant through which eligibility under this Plan has been derived.**
Employee Information	3. **Employee Social Security/I.D. Number:** Enter the identification number under which the employee and his/her dependents are enrolled. This will be the employee's Social Security Number (if applicable) or an identification number that has been assigned by Aetna International that may be found on your Aetna International Identification card. 4. **Employee Telephone:** Enter the Employee's telephone number. Please include country or city codes if required. 5. **Employee Address:** Enter the Employee's Street, City, State, Country, Postal, and Email Address information. 6. **If the Employee Is Not the Bank AccountHolder:** If wire payments are being requested for transfer into a bank account that is under a different name than the Employee, Provide the bank accountholder's telephone number.
Bank Information *(Contact your bank to complete / confirm the information in this section.)*	7. **Bank Name:** Enter the name of the bank or financial institution into which benefit payment(s) will be deposited. You shall notify Aetna International in writing of any changes to this information and note these transactions as a change in Section #13. Please be aware that it is the Employee's responsibility to appropriately communicate these changes, as the Employee will be responsible for any non-returned benefit payments distributed to your erroneously indicated account. 8. **Bank Identification Code/Routing Number:** Enter the bank "ID Code" (Routing Number) by which the bank can be identified for funds transfers. The covered member should contact their bank(s) to verify this number. Please indicate if this code is a S.W.I.F.T./BIC (used for wires), CHIPS UID, Federal ABA, Bank Sort identification code, IBAN or Other code. If the "Other" option is selected, please enter the code type in the space provided. 9. **Bank Account Number:** Enter the bank account number into which benefit payments should be transferred. 10. **Bank Accountholder's Name:** Enter the name of the bank accountholder into which benefit payments should be transferred. Enter this name as it appears on the Banking Statement. 11. **Bank Address:** Provide the phone number and address of the bank into which benefit payments are being deposited.
Payment Information	12. **Payment Information:** Check the box that indicates your preferred method of payment and specify a Country / Currency.
Recurring Reimbursement Election	13. **Reimbursement Election Request:** Check the box to indicate if this request is to either establish an initial recurring reimbursement election, to replace a previously requested recurring reimbursement selection with the newly supplied information, or to eliminate an existing reimbursement selection and revert to payment via US dollar checks.
Authorization	14. **Signature:** Both the Covered Member and the Bank Accountholder's (if different than the Covered Member) signature(s) and date(s) are required to authorize U.S. Dollar Wires and Non-U.S. Currency Claim payments.

Recurring Reimbursement Election

Aetna International

Contract Information

1. Group Control-Suffix-Account **724874 – _____ – _____**	2. Employee Name

Employee Information	**Bank Information**
3. Employee Social Security / I.D. Number	7. Bank Name
4. Employee Telephone Number	8a. Bank Identification Code / Routing Number
5a. Employee Street Address	8b. Bank ID Code Type: ☐ S.W.I.F.T./BIC (Wire only) ☐ CHIPS UID ☐ Federal ABA ☐ Bank Sort ID ☐ IBAN ☐ Other _____
5b. Employee City	9. Bank Account Number
5c. Employee State / Country	10. Bank Account Holder's Name (Exactly as it appears on the Bank Statement.)
5d. Employee ZIP / Postal Code	11a. Bank Street Address
5e. Employee Email Address	11b. Bank City
6. If the Bank AccountHolder is Different than the Employee, Provide the Bank AccountHolder's Telephone Number.	11c. Bank State / Country
	11d. Bank ZIP / Postal Code
	11e. Bank Phone Number (Including Country Code)

12. Payment Information

Check the box that indicates your preferred method of payment. Indicate the currency in which reimbursement is desired. (e.g. Great Britain / Pounds). If the currency you have elected is not available for the method you have requested, we will default reimbursement to US$. Aetna International can wire or Electronic Funds Transfer (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 transactions.

☐ Funds
Transfer (Preferred) – The most efficient method of receiving your benefits is via Funds Transfer. Please check with your bank for help with providing the appropriate instructions to Aetna International.

_____
(Indicate the requested **Country/Currency** in the space provided above.)

☐ Check

_____
(Indicate the requested **Country/Currency** in the space provided above.)

13. Recurring Reimbursement Election

Check the box that indicates your preferred recurring reimbursement election. (Based on the information listed in Boxes #7 to #12.)

☐ This is an **Initial Request** for the establishment of a recurring reimbursement election.
Please use this information for the delivery of all future reimbursements or until a change in reimbursement elections is made.

☐ This is a **Change Request**.
Please replace my previously established recurring reimbursement election with the information provided above or attached.

☐ This is a **Termination Request**.
Please eliminate my previously established recurring reimbursement election and revert to claim reimbursement via US dollar check.

14. Authorization (Signature and Date Required)

I, _____ (Employee's Name) hereby authorize Aetna Life & Casualty (Bermuda), Ltd., Aetna Life Insurance Company, and any of their affiliated companies ("Aetna") and/or its 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 above.

I agree to notify Aetna in writing of any change relating to the information provided on this form or of a 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 unearned payments, I will be personally liable for all costs of collection. These costs include reasonable attorney's fees, incurred by Aetna and/or its dedicated Agents in the collection of such payments, together with the maximum interest or charges permitted by law.

In the case of any overpayment of benefits to my account, I agree that Aetna may debit my account for such overpayment, without further authorization from me. I also acknowledge my responsibility to notify Aetna International in writing of any changes in the information indicated above.

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.

Employee's Signature (Include Bank Accountholder's Signature if Different than the Employee)	Date

Please Retain A Copy For Your Records

Coverage underwritten by Aetna Life Insurance Company and Aetna Life & Casualty (Bermuda) Ltd.

For Plans Compliant with United States Federal Affordable Care Act (ACA) legislation
Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

For language assistance in your language call the number listed on your ID card at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)

欲取得繁體中文語言協助，請撥打您 ID 卡上所列的號碼，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an. (German)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني المذكور في بطاقتك التعريفية. (Arabic)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo a yo endike nan kat idantifikasyon ou gratis. (French Creole)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente il numero riportato sulla Sua scheda identificativa. (Italian)

日本語で援助をご希望の方は、IDカードに記載されている番号まで無料でお電話ください。(Japanese)

한국어로 언어 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화번호로 전화해 주십시오. (Korean)

برای راهنمایی به زبان فارسی، بدون هیچ هزینه ای با شماره ای که بر روی کارت شناسایی شما آمده است تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer podany na karcie ID. (Polish)

Para obter assistência linguística em português ligue para o número grátis listado no seu cartão de identificação. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру, указанному в вашей ID-карте удостоверения личности. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số được ghi trên thẻ ID của quý vị. (Vietnamese)