



INTER-AMERICAN DEVELOPMENT BANK

Please mail completed Claim Form with itemized bills and receipts to:

International

DENTAL CLAIM FORM

For Mail Delivery: OR

For Courier Mail Delivery:

(800) 441-2668 (Inside USA)
(302) 797-3100 (Outside USA)
(302) 797-3150 (FAX)

CIGNA International
P. O. Box 15050
Wilmington, DE 19850-5050
USA

CIGNA International
590 Naamans Road
Claymont, DE 19703
USA

10/23/01

You must complete Sections A and B. In addition, you must complete Section C if the claim is for a dependent and/or other coverage is in effect. Employee must sign Claim Form. You must complete a separate Claim Form for each patient. You may include multiple services for the same patient on the same Claim Form.

SECTION A. EMPLOYEE/PATIENT INFORMATION

Employer INTER-AMERICAN DEVELOPMENT BANK Patient's Name

Employee's Name Policy # on CIGNA ID Card 0039A0999

Employee/Retiree Number, if applicable

Home Address

Please provide telephone and facsimile numbers, with country and city codes, and indicate where you wish to be called:

Home # Work # Fax #

SECTION B. PAYMENT. Please select Option # 1 or Option # 2. Payment will be in United States Dollars.

OPTION # 1 (You wish payment to be made payable to you, the Employee).

Please indicate where you wish the payment to be sent. You must be an owner of the bank account to which funds are to be sent.

Your home address as listed above

Your bank account for direct deposit

Name on Account Bank Name

Bank Account # Bank Address

OPTION # 2 (You wish payment to be made payable to the PROVIDER).

Please complete Provider's name and address in Section D on the reverse side of this Claim Form.

WARNING Any person who files a statement of claim containing any false, incomplete or misleading information, who knowingly and with intent to injure, defraud, or deceive any insurer, is guilty of a crime.

Payment Authorization: I authorize payment directly to me or to the dentist in Section D of this Claim Form.

EMPLOYEE'S SIGNATURE: DATE (M/D/Y):

Patient's Signature Release (Parent or Guardian, if claim is for a minor): I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading or incomplete information. I authorize the release of all dental records or other information which may be necessary to determine benefits payable.

PATIENT'S SIGNATURE: DATE (M/D/Y):

SECTION C. OTHER COVERAGE INFORMATION. If the claim is for a dependent and/or other coverage is in effect.

Do you have any other insurance? Yes No If yes, please provide source of insurance.

Please indicate source _____

Spouse's name _____

Spouse's insurance company _____

Spouse's employer and telephone # _____

Dependent's date of birth (M/D/Y) _____ Is your dependent a full-time student? Yes No

If yes, please provide documentation of current academic registration.

SECCION D. DENTIST. Please complete this section.

Name, address, and telephone # of dentist of service _____

Patient's account # _____ Place of Service _____

Examination and Treatment Plan - List in order from tooth No. 1 through tooth No. 32. Please use chart system shown.

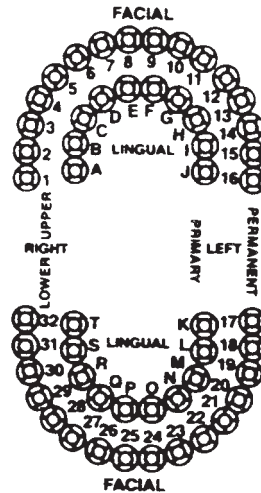
Please check one and specify date

Predetermination of Benefits

Statement of Actual Services

Date:

Please indicate missing teeth with an "x"



Tooth # or Letter	Surface	Description of Procedure	Date of Service	Total Charges	Fee Paid	Fee Due

I certify that the foregoing information is true and correct and that the charges are the actual charges to the patient.

DENTIST'S SIGNATURE: _____ DATE (M/D/Y) _____