Electronic Fund Transfer (EFT) Enrollment Form

Mailing Address: P.O. Box 15050
Wilmington, DE 19850, USA

Fax: 1.800.243.6998 (outside the USA)
001.302.797.3150 (inside the USA)

Please Read, Important Information:
To enroll for EFT, please complete the following information and submit this form along with a *voided check* to Cigna Global Health Benefits.

Cigna ID Number: *(Not required for new members)*	Employee Name (First, Last):		
Employer:	Check One: ☐ Enrollment for EFT ☐ Change to Existing Account		
Daytime Telephone Number: *(In the event there are questions about the information provided, please include country and city codes)*			
Email Address: *(Will be used to send deposit notification)*			
U.S. Bank Information – This information is required along with a voided check			
U.S. Bank Name:			
U.S. Bank Address: *Street*	*City:*	*State:*	*Postal / ZIP Code:*
Name on U.S. Bank Account:			
Account Type: (Check One) ☐ Checking ☐ Saving	Account Number:	Bank Routing Code: *(9-Digit code located on the bottom left corner of check)*	

Deposit Authorization:
I hereby authorize Cigna Global Health Benefits to deposit my claim reimbursements in U.S. Dollars into the financial institution named above and I hereby authorize that institution to credit these deposits to my account. This authorization is to remain in effect until I notify Cigna Global Health Benefits in writing of a cancellation or change, allowing reasonable time to implement such cancellation or change. I understand that it is my responsibility to verify that the funds are in my account correctly or to notify Cigna Global Health Benefits immediately of any discrepancies. I hereby agree to hold Cigna Global Health Benefits harmless from any error or omissions they may make in depositing or failing to deposit any claim reimbursements to the designated account.

Employee Signature: _____ **Date:**

If name on bank account is different than the insured, then the owner of the bank account must also sign giving Cigna Global Health Benefits the authority to deposit funds into their bank account.

Account Owner Signature: _____ **Date:**

All claim payments will be electronically transferred to your bank account unless otherwise specified by you on the claim form or unless benefits have been assigned to the Provider of service(s).
When a benefit payment is transferred to your bank account you will receive an e-mail notifying you of the deposit at the e-mail address you have provided above. Cigna Global Health Benefits cannot guarantee the confidentiality of this information when exchanged over the Internet. If you would prefer not to receive electronic reimbursement notification, do not provide your e-mail address. In either case, an Explanation of Benefits (EOB), explaining the reimbursement in detail will be mailed to you. You may also view your reimbursement information on-line at http://www.cignaenvoy.com

FRAUD NOTICE: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.