This original form, duly completed and signed, should be returned to:

Cigna
P.O. Box 69
2140 Antwerpen
Belgium

SEPA Direct Debit Mandate

By signing this mandate form, you authorise (A) Cigna to send instructions to your bank and to debit your account and (B) your bank to debit your account in accordance with the instructions from the Creditor. **Please inform your bank that you have given Cigna the authorisation to debit your account.**

As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks starting from the date on which your account was debited. Your rights are explained in a statement that you can obtain from your bank.

Creditor

Name Cigna International Health Services BVBA

Address Plantin en Moretuslei 299
2140 Antwerpen

Identifier BE74ZZZ0414783183

Mandate reference (reserved for the creditor)

Debtor

Name - First name

Cigna pers. ref. no. or product name

Date of birth

Address

Postal code City/Town Country

Swift/BIC

Account number - IBAN

◯ This account number may be used for the reimbursement of my medical expenses

◯ I would like the reimbursment of my medical expenses to come in a different account:

Name - First name

Bank name

Bank address

Swift/BIC

Account number - IBAN

I accept the terms and conditions. I certify that the above information is to the best of my knowledge and belief correct and true. The issuance of false claims, the provisions of misleading information or the withholding of information related thereto is an offence punishable by Law. I hereby confirm that I have read and fully understood Cigna's Data Protection Notice (https://www.cignahealthbenefits.com/en/privacy). If I provide Cigna with personal information relating to others, I will make them aware of Cigna's Data Protection Notice.

Date (d-m-y) Location

Signature

5.40.305_EN (0119)