



Archipelago™

Archipelago Insurance Limited
Unit 3A-25
Labuan Times Square
U0350, Jalan Merdeka
87007, F.T. Labuan
Malaysia

Dear

Claimant name:
Claimant's member ID:
Planholder name:
Plan number:

We have received your claim for the amount of
You have requested that we pay any eligible costs for this claim into the following account:

Payee name:
Account number:
Bank and Branch name:
Bank code:

We notice that the payee name is different to your name or the name of any adult dependent on your policy. Please fill in the payee details on the next page and send it back to us at the address above or you can email a scanned copy to us at along with the requested additional documentation if applicable, so that we can review your request. This does not guarantee that we will be able to make payments to your nominated payee.

We also need to make you aware that if the payment to the payee is approved by us and such payment is made, the payee will receive a Claims statement containing information which may allude to the symptoms or medical condition for which the treatment costs were incurred.

Please confirm if the payee is an Individual or Company/Entity

<input type="checkbox"/> Individual	Complete section A and C
<input type="checkbox"/> Company/Entity	Complete section B and C

Section A: Individual

First name	Middle name	Last name
Date of birth (dd/mmm/yyyy)	Nationality	Country of residence / location
Payee phone number	Payee email address	
The relationship between yourself and the payee	Your full name	
Your signature		

Section B: Company/Entity

Full name	
Complete address	
Country of corporation	Payee phone number
Payee email address	
The relationship between yourself and the payee	Your full name
Your signature	

Section C

Has the payee paid the costs for the treatment that you are claiming for? <input type="checkbox"/> Yes <input type="checkbox"/> No
If 'Yes', provide evidence. (add this only if the invoices / receipts are not in that third party name)
If 'No', confirm the reason you have requested we pay them instead of yourself.

Yours sincerely,

Claims Team

Email: AsiaPacServices@aetna.com

Phone: +60-3-7724-4179

Fax: +65-6395-6747

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Important: This is a non-US insurance product that does not comply with the US Patient Protection and Affordable Care Act (PPACA). This product may not qualify as minimum essential coverage (MEC), and therefore may not satisfy the requirements, if applicable to you and your dependants, of the Individual Shared Responsibility Provision (individual mandate) of PPACA. Failure to maintain MEC can result in US tax exposure. You may wish to consult with your legal, tax or other professional advisor for further information. This is only applicable to certain eligible US taxpayers.