

Collins Retirees Health Benefit Claim Form – Outside U.S.A

To be filled out by Collins Retirees residing outside United States

Name of Retiree: _____ **ID No.** _____

Street Address: _____ **City** _____ **Zip** _____

Country: _____

Email Address: _____ **Country Where Services Received:** _____

Medical Reimbursement Options: (Please check appropriate)

- Direct Deposit to my Collins Pension Bank account in the U.S.** (foreign bank wire not available)
- Mail my medical reimbursement check(s) to my home address listed above.**

Are you enrolled at the Public Health Plan in the country of residence outside United States?

Yes No

List country of residence _____

*****All information must be filled out completely in order for you to receive payment*****

Patient	Date of Birth	Date of Service	Description of Service (Medical/Hosp./Rx/Dental)	Amount in Local Currency	Exchange Rate Per US\$:	Amount in US\$

Retiree's Signature: _____ Date: _____