

Claimant information

First Name:	
Last Name:	
Fiscal ID N°:	
Company name (if Claimant is a legal person):	
Address:	
Phone:	Mobile phone:
E-mail:	
Policy N°:	Insurance type:

Claimant is the:

- ☐ Policyholder (person who purchased the insurance)
- ☐ Insured (person covered by the insurance policy)
- ☐ Beneficiary (for life/accident insurance policies – person receiving compensation)
- ☐ Legal beneficiary

Please provide documentary proof of your status as legal beneficiary

Representative information If other than claimant:

First Name:
Last name:
Fiscal ID N°:

Please provide a copy of the relevant power of attorney

Your complaint or claim

Please state if your complaint or claim refers to a particular Cigna office/department or an agent or insurance broker:

What would you like Cigna to do following consideration of your complaint or claim? Please describe:

- List of attachments:
1. _____
 2. _____
 3. _____

Claimant represents that the issue to which this complaint or claim refers is not the object of any administrative, arbitration or court procedure.

Your complaint or claim (to be continue)

Please describe

Signature: Done at _____, on _____ of _____ 202 _____

The personal data included in this form will be processed for the purposes of settling claims and complaints, and will be stored in a filing system owned and kept by Cigna. Personal data may also be processed for the purposes of preventing and investigating fraud. Interested parties may access, rectify, cancel and oppose the processing of their personal data contained in said filing system, in accordance with Ley Orgánica de Protección de Datos (Spain's Data Protection Act), by sending a request to Parque Empresarial La Finca, Paseo del Club Deportivo, I, Edificio I4, Planta primera, 28223 Pozuelo de Alarcón (Madrid) or by emailing proteccion.datos@cigna.com.