Senior Service Medical Plan (SSMP) – Outside the United States
Form to Request a Guarantee of Payment (GOP) for Care.
For use by the **Missions/Missionaries** of **The Church of Jesus Christ of Latter-day Saints**

Instructions: Complete below or be prepared to provide this information when emailing or placing a phone call **before** you seek care. **Information below is needed whether request is made via Email or Phone.**

Requestor's Name:
Requestor's relationship to the Patient:
Requestor's email:
Requestor's Phone Number *(including Country & City Code)*:
Requestor's Location *(City/Country)*:
Email Address(es) of any other contacts who should receive a copy of the GOP when issued:
Patient's FULL Name (First & Last):
Patient's Aetna W ID #:
Patient's Date of Birth (*please use* mm/dd/yyyy *format*):
What is the nature of the illness/injury/medical complaint *(A brief explanation of symptoms. Ex. Knee pain, sore throat, abdominal pain, etc.)*:
Type of service(s) needed/requested *(ex. MD consultation, ER visit, Hospital Admission, etc.)*:
Date of Service/Admission *(planned or emergency):*
Facility/Provider name *(please be as specific as possible with facility/provider's name)*:
Facility/Provider address/GPS location:
Facility/Provider phone number:
Physician Name *(if known)*:
Physician Specialty *(if known)*: