

# CLAIM FORM

This form is applicable to all products of Bupa México, Compañía de Seguros, S.A. de C.V.



## PRIVACY NOTICE

Bupa México, Compañía de Seguros, S.A. de C.V. (hereinafter “Bupa México”), with its address located at Montes Urales 745, 1st, floor, Lomas de Chapultepec, Miguel Hidalgo, Zip Code 11000, Mexico City, Mexico, in its capacity as Controller under the terms of the provisions of the Federal Law on Protection of Personal Data held by Private Parties (Ley Federal de Protección de Datos Personales en Posesión de los Particulares) makes this privacy notice available to you, for the purpose of conducting the legitimate, controlled, and informed processing of your personal data, and for the purpose of guaranteeing the privacy of your personal data, and your right to self-determination of your information. We remind you that the information contained in this form will be used to process and follow-up on your claim, therefore, we require your express written consent at the end of the document. For more information on the terms of the processing of your Personal Data, and to exercise your rights of access, rectification, cancellation and objection (ARCO), we invite you to read our Comprehensive Privacy Notice, which is available at [www.bupasalud.com.mx](http://www.bupasalud.com.mx).

## INSTRUCTIONS

1. This form must be filled with single-color ink, in legible handwriting, and it must have the handwritten signature of the Insured. It will not be valid with erasures or amendments, and no subsequent changes to the statements provided herein will be accepted.
2. It is necessary to fill the form in full and provide complete and detailed information.
3. As a result of providing this form, Bupa México is not required to admit the validity of the claim or waive the rights that it reserves according to this policy.

## 1. TYPE OF CLAIM

Accident    Pregnancy    Disease    Reimbursement    Direct payment    Policy No.

## 2. INFORMATION ON THE AFFECTED INSURED

Name(s) of the affected insured		Paternal last name	Maternal last name	Name	
Tax ID (RFC)				CURP	
Date of Birth	DD	MM	YYYY	Sex: F M	Nationality
Telephone				Email	
Occupation or profession				Line of business of the company	
Place of work (company) / Study (school)					
Have you filed previous expenses for this disease or accident in this or another company?				Yes No	Date of Claim DD MM YYYY
Address of the Affected Insured					
Street			External Number		Internal Number
Neighborhood			City		State
Municipality			Zip Code		Country
Do you have other insurance?	Yes No	Company			
Incident				Policy No.	
Hospital where the insured was treated					
No. of days of stay		Date of entry: DD MM YYYY		Date of exit: DD MM YYYY	

## 3. DETAILS ON THE CLAIM (TO BE FILLED BY THE INSURED)

Date on which the accident happened, or the first symptoms of the disease appeared	DD	MM	YYYY
Date of the first visit to the physician for this disease	DD	MM	YYYY

Specify the type of alterations and/or symptoms that occurred	Specify the diagnostic that led to the claim

#### 4. NOTICE OF ACCIDENT

Details - How and when did it occur?		Traffic accident
 		Yes No
Brand	Model	Plate Number
Insurance company of the Third Party		Third Party Policy
Incident	Attach a copy of the documents provided to you	
Authority that was informed of the accident		
File number	Attach a copy of the provided documents	
Insured amount		

#### 5. IN CASE OF HOSPITALIZATION

Name of the hospital	 							
Hospitalization period	From:	DD	MM	YYYY	To:	DD	MM	YYYY

#### 6. IN CASE OF MINORS

Name	Relationship	Signature (Responsible relative)

#### 7. SIGNATURE

Place	Date:	DD	MM	YYYY
Name and signature (Affected insured)				

#### 8. TO BE FILLED BY THE ATTENDING PHYSICIAN

Diagnostic made and studies conducted		 						
Is your disease related to another disease? Yes No to which and why?		 						
Clinical condition (signs and symptoms)	Treatment			 				
Description of the complications		 						
Budget of professional fees / Direct payment								
Name							Budget	
Place of treatment (hospital)								
Date of entry:	DD	MM	YYYY	Date of exit:	DD	MM	YYYY	Were there any complications? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of the attending physician		 						
Professional License	Tax ID (RFC)			 				
E-mail	Telephone			 				
Signature of the attending physician	Date	DD	MM	YYYY	Place	 		

**9. IN CASE OF USING AN ADDITIONAL SUPPLIER OF MATERIALS AND INPUTS, FILL OUT THE SECTION BELOW**

Name of the supplier		Tax ID (RFC)	
Address			
Telephone		Date	DD MM YYYY

**10. DETAILS ON THE TREATMENT RECEIVED (INCLUDE ATTACHED SHEET IF NECESSARY)**

Date of the service	Name of the supplier / Attending physician	Description of the service / Specialization(s)	Currency	Amount
DD MM YYYY				
DD MM YYYY				
DD MM YYYY				
DD MM YYYY				
DD MM YYYY				
Total amount				
Amount paid by the insured				

**11. DATA TRANSFER**

The data owner authorizes Bupa México to share its personal and sensitive data with its insurance agent or broker to follow up on this reimbursement request.

I allow Bupa México to transfer my personal and sensitive data.

Bupa México cannot transfer my personal and sensitive data.

**12. SIGNATURE**

Place:		Date	DD MM YYYY
Name and signature (Insured beneficiary of the payment)			

**Bupa México, Compañía de Seguros, S.A. de C.V.**

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**Specialized Customer Service Unit (UNE)**

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