FORM FOR MEDICAL EXPENSES REIMBURSEMENT REQUEST

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.

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. GENERAL IDENTIFICATION DATA OF THE CONTRACTING PARTY (THE PERSON THAT PAYS THE PREMIUM)

☐ Individual ☐ Legal Person

Company Name / Full name	Paternal last name	Maternal last name	Name

Date of Birth	Date of Organization	Country of Birth (Individual)	Nationality
DD MM YYYY	DD MM YYYY		

Tax ID (RFC)	Serial no. of the digital certificate of the advanced electronic signature (if any)

Profession or occupation (individual) – provide details	Purpose or line of business (legal person)

Commercial folio (legal person)	Tax ID No. (only for foreigners)	CURP

Street		Exterior No.		Interior No.	
Neighborhood		Zip Code		State	
Municipality		City or population			
Private telephone		Email			

2. GENERAL IDENTIFICATION INFORMATION OF THE MAIN INSURED(THE PERSON THAT PAYS THE PREMIUM (if the information is the same as that of the policyholder, it will only be necessary to confirm it with this box: ☐)

Full name	Paternal last name / Maternal last name / Name	Date of Birth	DD MM YYYY
Country of birth		Tax ID (RFC)	
Profession or occupation		CURP	
Address			
Telephone		Email	

2. 3. GENERAL IDENTIFICATION DATA OF THE AFFECTED INSURED
(if the information is the same as that of the policyholder, it will only be necessary to confirm it with this box: ☐)

Name of the affected insured		Date of Birth	DD MM YYYY
Telephone		Email	

4. BANK ACCOUNT HOLDER DATA (TO WHICH THE PAYMENT MUST BE MADE)
Please mark whether the holder of the account is the main insured or the policyholder

Main Insured ☐	Policyholder ☐
CLABE (18 digits)	
Name of the Bank	

I hereby request and authorize Bupa México, for any applicable payment owed to me as Main Insured and/or policyholder or in favor of the Insured Persons, derived from the abovementioned Insurance Agreement, to be deposited in the bank account under my name or under the name of the beneficiary of the payment.
The insured represents, under oath, that the bank account number provided herein is under its name, therefore, in case of providing incorrect information or an account for the benefit of a third party, the interested party releases Bupa México from all liability for the payments/deposits or transfers to the aforementioned account, or for the applicable amounts according to the insurance agreement, and to the conditions of the policy, will be deemed recognized and made to its full satisfaction, granting Bupa México the broadest settlement and release that is applicable by law, without reserving any action or right to be exercised against this company as a result of the payments made. Likewise, it henceforth assumes any obligation vis-à-vis third parties that may be derived from such payments, releasing Bupa México from any claim arising as a result of the performance of the aforementioned insurance agreement.
Important information related to the reimbursement:

- It is indispensable for the aforementioned bank account to be under the name of the payment Beneficiary.
- The physical documentation provided to this company of the claim(s) will remain in the office that receives it for processing for 30 calendar days, and it will then be attached to the file of the claim. The delivery thereof will be at the express request of the Main Insured upon prior review and, as applicable, acceptance of its request by the Insurance Company.
- Provide a bank account statement that contains the CLABE under the name of the payment beneficiary, which is no older than 3 months following its issue (it must be filed once, and in case of change of bank account).
- In subsequent claims, it is only necessary to file the request for reimbursement with the relevant bank information.

5. BANK ACCOUNT HOLDER IDENTIFICATION

Exclusive for individuals.

Mention whether you, your spouse, or a collateral relative up to the second degree perform important public duties in a foreign country or in Mexican territory, has been a head of state or government, high-ranking political leader, government, judicial, or military official, senior executive of state-owned companies, official or member of political parties.		Yes ☐ No ☐	
If yes, describe the position:		Relationship or link	
Does this person have shares or property links with any company or association? Yes ☐ No ☐			
Specify			
Do they act on their own behalf? Yes ☐ No ☐	If no, mention the name of the third party on bethalf they act		
Legal action through which mandate was obtained		Relationship with you	
Are you shareholder or member of any company or association? Yes ☐ No ☐			
Name		Percentage interest:	
Name and signature of the payment beneficiary:			

6. TYPE OF CLAIM

☐ Initial (Is it the first time that you file expenses for this event?)	☐ Supplementary (When expenses have already been submitted for this)

7. IN CASE OF SUPPLEMENTARY CLAIM, PLEASE SPECIFY:

Diagnostic		Policy No.	
Please specify which documents are being provided: Payment receipts and specify the invoice number		Total claimed amount	$

Invoice No.	Claimed amount	Invoice No.	Claimed amount	Invoice No.	Claimed amount
1	$	8	$	15	$
2	$	9	$	16	$
3	$	10	$	17	$
4	$	11	$	18	$
5	$	12	$	19	$
6	$	13	$	20	$
7	$	14	$	21	$

Name and signature (Insured beneficiary of the payment)			
Provision of the accident and/or disease notice	Yes ☐ No ☐	Provision of medical report, clinical summary, or clinical history	Yes ☐ No ☐
Delivery of results of studies Yes ☐ No ☐ Which			
Delivery of other documents Yes ☐ No ☐ Which			

8. 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.

9. SIGNATURE

Place:		Date	DD MM YYYY
Name and signature of the policyholder and/or main insured			
Name and signature of the affected insured			

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