CLAIM FORM

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

PRIVACY NOTICE

Bupa México, with its address at Montes Urales 745, 1st floor, Lomas de Chapultepec, Miguel Hidalgo, Zip Code 11000, Mexico City, Mexico. We remind you that the information collected through this form will be used to process and follow-up on your claim, therefore, we require your express written consent at the end of this document.

For more information on the terms of the processing of your personal data, and how to exercise your ARCO rights, we invite you to check our Comprehensive Privacy Notice, available at www.bupasalud.com.mx.

INSTRUCTIONS

1. This form must be filled with a single ink, and must have the handwritten signature of the affected insured and attending physician. It will not be valid with cross-outs or erasures, and no subsequent changes to the statements herein will be accepted.
2. It is necessary to fill out the full form and provide complete and detailed information.
3. As a result of providing this form, Bupa México Compañía de Seguros, S.A. de C.V., is not required to admit the validity of the claim or waive the rights it reserves according to the policy.
4. This form must be accompanied with the following documentation:
   a. Official valid ID of the affected insured.
   b. All laboratory, clinical, pathology analyses and prescriptions on which the diagnostic is reasoned.
   c. In case of a request for refund, it is necessary to attach the "Refund Request Form".
   d. In case of a medical service preauthorization request, please attach all laboratory, clinical, pathology analyzes and prescriptions on which the diagnostic and the need for the requested treatment are reasoned.
   e. In case of an accident, Bupa reserves the right to request toxicological tests and relevant reports from competent authorities and/or health service providers. In case of an accident as a driver of motor vehicles or transportation, it is necessary to attach toxicological tests and relevant reports from the competent authorities to complete the report. If the vehicle is insured, please attach a copy of the accident report from the insurance company and/or a copy of the Universal Statement of Accident of the insurance company.

1. TYPE OF CLAIM (PICK ONE OF THE FOLLOWING OPTIONS):

☐ Direct payment to health provider or scheduling of medical service	☐ Preauthorization of medical service	☐ Reimbursement		
Choose one of the following options: ☐ Accident	☐ Disease	☐ Pregnancy	Policy No.	

2. INFORMATION ON THE AFFECTED INSURED

Name of the affected insured	Paternal Last Name	Material Last Name	Name (s)
Tax ID		Nationality	
Date of Birth	DD / MM / YY	Sex	☐ Female ☐ Male
Telephone		Email	

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

3.1 Indicate the type of alterations and/or symptoms that you suffered

3.2 Were you hospitalized as a consequence of this disease, accident, or severe medical emergency? ☐ Yes ☐ No If yes, answer the following questions:					
No. of hospitalized days		Entry date	DD / MM / YY	Exit date	DD / MM / YY
3.3 Indicate the diagnostic for your claim					
3.4 Date when the condition started	DD / MM / YY	3.5 Date of first attention	DD / MM / YY		
3.6 Do you currently have another major medical health insurance? ☐ Yes ☐ No If yes, answer the following questions:					
Company		Policy No.			
3.7 Have you submitted prior expenses for this condition or accident with this or another company? ☐ Yes ☐ No If yes, answer the following questions:					
Case no.		Date claim:	DD / MM / YY		
Name of health provider where you were attended					

4. IN CASE OF ACCIDENT OR SEVERE MEDICAL EMERGENCY, ANSWER THE FOLLOWING QUESTIONS

4.1 Describe with the greatest detail possible how and when the accident or severe medical emergency happened and the injuries you suffered as a result thereof.
4.2 Traffic accident ☐ Yes ☐ No

5. IN CASE OF HOSPITALIZATION SCHEDULING (FILL IF APPLICABLE)

5.1 Hospital Name				
5.2 Hospitalization period	From	DD / MM / YY	To	DD / MM / YY

6. SECTION TO BE FILLED BY THE ATTENDING PHYSICIAN. YOU MAY ALSO SEND A MEDICAL REPORT WITH LETTERHEAD, SIGNED BY THE ATTENDING PHYSICIAN AND WITH THEIR PROFESSIONAL LICENSE NUMBER

6.1 Indicate the name of the affected insured:

6.2 Indicate the diagnostic

6.3 Studies carried out to determine the diagnostic

6.4 Date on which the diagnostic was determined DD / MM / YY

6.5 Is this condition related to another condition? ☐ No ☐ Yes If yes, describe which and why:

6.6 Clinical conditions (signs and symptoms)

6.7 Treatment

6.8 Were there complications? ☐ Yes ☐ No If yes, describe the complications:

MEDICAL FEES BUDGET FOR DIRECT PAYMENT

Date of Service	Name of the provider / attending physician	Specialization	Professional license	Description of the service	Amount in Mexican Pesos
DD / MM / YY					
DD / MM / YY					
DD / MM / YY					
DD / MM / YY					
DD / MM / YY					
Total					
Budget					

INFORMATION OF THE ATTENDING PHYSICIAN

Name	Specialization	Professional license	Telephone	Signature

7. IN CASE OF USING AN ADDITIONAL PROVIDER OF MEDICAL MATERIALS, FILL THE FOLLOWING SECTION			
7.1 Name of the provider		7.2 Tax ID	
7.3 Address			
7.4 Telephone		7.5 Date	DD / MM / YY
7.6 Total for the services		Please attach the detailed budget of the services to be provided	

8. PERSONAL DATA TRANSFER

In addition to transfers of personal data permitted by applicable law and for the purpose of complying with the primary and secondary purposes established in our Privacy Notice, you authorize Bupa Mexico to carry out the transfer of personal data with:

- Your agent or broker. Providers with assistance services.
- Hospital providers. Ambulatory service providers.
- Medical and telemedicine providers. Reinsurers and Coinsurers.

Please choose a mandatory option:

I expressly consent that my data be transferred: ☐ Yes ☐ No

9. SIGNATURE OF THE AFFECTED INSURED			
Place:		Date:	DD / MM / YY
Name and signature (Affected insured)			

10. IN CASE OF MINORS OR IMPOSSIBILITY OF THE AFFECTED INSURED TO SIGN			
Name:		Relationship:	
Place:		Date:	DD / MM / YY
Signature of the mother, father, guardian, or representative			
Attach a copy of the official ID with signature of the mother, father, guardian, or representative that signs.			

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