MEDICAL EXPENSE REFUND REQUEST FORM

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

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 to provide complete and detailed information.
3. By 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.

NOTE

1. 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 additionally attach the "Claim Form".
   d. In case of a medical service preauthorization request, attach all laboratory, clinical, pathology analyses and prescriptions on which the diagnostic and the need for the requested treatment is 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 Accident Statement of the insurance company.

1. GENERAL IDENTIFICATION INFORMATION OF THE INDIVIDUAL PAYING THE PREMIUM

Full name (paternal last name, maternal last name, name[s])			Policy No.
Date of Birth Month Day Year	Country of birth	City or Town of Birth	CURP (if applies)
Nationality		Tax ID	
Serial No. of the digital certificate of the advanced electronic signature (if any)			
Occupation		Tax ID (for foreigners, if any)	

GENERAL IDENTIFICATION INFORMATION OF THE ENTERPRISE/COMPANY PAYING THE PREMIUM

Name			Policy No.
Organization Date Month Day Year	Commercial folio	Tax ID (for foreigners, if any)	
Nationality		Tax ID	
Purpose or line of business		Serial No. of the digital certificate of the advanced electronic signature (if any)	

ADDRESS (FOR INDIVIDUALS OR LEGAL COMPANIES)

Street		Outside No.	Interior No.
Neighborhood		Municipality or borough	State
City or town	Zip Code	Telephone	Email

2. GENERAL IDENTIFICATION INFORMATION OF THE MAIN INSURED
(if the information is the same as that of the payer, it will only be necessary to confirm it in this box: ☐)

Full name:		Date of birth:	Month / Day / Year
Tax ID:		Telephone:	

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

Name of the affected insured:		Telephone:	
Date of birth:	Month / Day / Year	Email:	

4. TYPE OF CLAIM

☐ Initial (It is the first time submitting expenses for this event)	☐ Supplementary (If expenses have already been submitted for this event)	Diagnostic	

Please indicate the number of each invoice and the amount corresponding to each of them:			Total claimed amount	$	
Invoice No.	Claimed amount	Invoice No.	Claimed amount	Invoice No.	Claimed amount
1	$	7	$	13	$
2	$	8	$	14	$
3	$	9	$	15	$
4	$	10	$	16	$
5	$	11	$	17	$
6	$	12	$	18	$

Provision of medical report, clinical summary, or clinical history	☐ Yes ☐ No
Provision of study results	☐ Yes ☐ No Which
Provision of other documents	☐ Yes ☐ No Which

5.IDENTIFICATION OF BANK ACCOUNT HOLDER
Additional information only for an individual or legal representative

Do you or any relative occupy a position in government? ☐ Yes ☐ No	Define title	Department
Do you act on your own behalf ☐ Yes ☐ No	If not, mention the name of the third party which you represent:	
Name and signature of the payment beneficiary:		

6. INFORMATION OF THE HOLDER OF THE BANK ACCOUNT (TO WHICH PAYMENT MUST BE MADE)
Please mention if the holder of the account is the holder or payer

☐ Insured ☐ Payer	Bank account registration ☐ Do you wish to update bank account? ☐ Yes ☐ No
CLABE (18 digits)	
Bank Name:	

I hereby request and authorize Bupa Mexico so that any payment authorized to me as Main Insured and/or policy holder 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 of a third party, the interested party releases Bupa Mexico from all liability for the payments/deposits made to such accounts. Additionally, it expressly represents that when the deposits or transfers are made to the aforementioned account, or the amounts authorized in accordance with the insurance agreement and the conditions of the policy, these will be deemed recognized and made to its full satisfaction, granting Bupa Mexico the broadest settlement and release applicable by law, not reserving any action or right to be exercised against this institution 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 Mexico from any claim arising from compliance with the aforementioned insurance agreement.

Important information relating to your refund:

- It is indispensable that the abovementioned bank account is under the name of the Beneficiary.
- The physical documentation regarding the provided to this company will remain in the office that receives the process for 30 calendar days, then they will 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 your request by the insurance Company.
- Provide bank account statement containing the CLABE under the name of the payment beneficiary, which is no older than three months (it must be filed only once, and in case of a change of bank account).
- In subsequent claims, it will only be necessary to submit the request for reimbursement with the relevant bank information.

7. SIGNATURE

Place:		Date:	Month / Day / Year
Name and signature of the payer and/ or insured			
Name and signature of the affected insured			

8. PRIVACY NOTICE

Bupa México, Compañía de Seguros, S.A. de C.V., ("*Bupa México*") with address located at Ejercito Nacional Avenue, number 843-B, Antara I Corporate Building, 9th floor, Granada, Miguel Hidalgo, Zip Code 11520, Mexico City as Data Processor, in terms of the provisions of the Federal Law on Protection of Personal Data Held by Private Parties, its Regulations and other applicable secondary regulations ("LFPDPPP"). We use your personal data primarily to provide advice and updates on the products contracted; create and manage your online services profile and update your personal file; process payments and refunds; process claims and reimbursements; placement of risks in reinsurance and / or coinsurance. We also use them to send you communications with relevant information, promotion and advertising; develop behavioral profiles and preferences about the use and consumption of our products. For more information about the terms and conditions of the processing of your personal data, and how to exercise your ARCO rights you can download our Privacy Notice on www.bupasalud.com.mx.

PERSONAL DATA TRANSFERS

The data owner authorizes Bupa Mexico to share with its agent or insurance intermediary his personal and sensitive data to follow up on this request.

- ☐ I accept the transfer of my personal and sensitive data
- ☐ I do not accept the transfer of my personal and sensitive data

Bupa Mexico, Compañia de Seguros, S.A. de C.V.
Ejercito Nacional Avenue #843-B, Antara I Corporate Building, 9th floor,
Granada, Miguel Hidalgo, Zip Code 11520 • Mexico City
Tel. 55 5202 1701 • 800 227 3339 • atencioncliente@bupa.com.mx • www.bupasalud.com.mx

Specialized Customer Service Unit (UNE)
Ejercito Nacional Avenue #843-B, Antara I Corporate Building, 9th floor,
Granada, Miguel Hidalgo, Zip Code 11520 • Mexico City