CLAIM FORM

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

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

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	Maternal Last Name	Name (s)
Tax ID		Nationality	
Date of Birth	Month / Day / Year	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	Month Day Year	Exit date	Month Day Year

3.3 Indicate the diagnostic for your claim

3.4 Date when the condition started	Month Day Year	3.5 Date of first attention	Month Day Year

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:	Month Day Year
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	Month Day Year	To	Month Day Year	

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 — Month / Day / Year

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
Month Day Year					
Month Day Year					
Month Day Year					
Month Day Year					
Month Day Year					
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	Month Day Year
7.6 Total for the services		Please attach the detailed budget of the services to be provided	

8. SIGNATURE OF THE AFFECTED INSURED			
Place:		Date:	Month Day Year
Name and signature (Affected insured)			

9. IN CASE OF MINORS OR IMPOSSIBILITY OF THE AFFECTED INSURED TO SIGN			
Name:		Relationship:	
Place:		Date:	Month Day Year
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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