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.

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? ☐ Yes ☐ 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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