APPLICATION TO REQUEST REVIEW OF EXCLUSIONS AND/OR LIMITATIONS

To be completed by the policyholder
(PLEASE USE BLOCK LETTERS)

1. POLICYHOLDER'S INFORMATION

Name	Last	First	M.I
Policy number			

Insured person to whom the exclusion and/or limitation applies.

Last	First	M.I

Text of the exclusion and/or limitation to be reviewed.

Date of the last three (3) consultations for whom the limitation and/or excluded condition applies, and include recently updated medical information (LAB TESTS AND EXAMS)

MM / DD / YYYY	MM / DD / YYYY	MM / DD / YYYY

Describe the current medical status of the insured to whom the limitation and/or excluded condition applies.

Name of hospital	Address	Telephone

2. TREATING PHYSICIAN'S INFORMATION

Name	Last	First	M.I
Address			
Telephone		Fax	
Email			

3. SIGNATURE

I hereby certify that the person to whom the exclusion and/or limitation applies has been free of symptoms and/or signs of the medical condition that originated the exclusion and/or limitation as of _____, and said person has not required any kind of medical treatment for such condition. I am willing to provide Bupa with any medical evidence considered necessary to evaluate the above-mentioned exclusion and/or limitation.

Policyholder's signature		Date	MM / DD / YYYY

18001 Old Cutler Road, Suite 500, Palmetto Bay, Florida 33157
Tel. +1 (305) 275 1500 , +1 (800) 321 5187 • Fax +1 (305) 275 1518 • www.bupasalud.com/MyBupa • bupa@bupalatinamerica.com