BlueCross BlueShield Panama

REQUEST FOR MEDICAL INSURANCE

Complete in BLOCK LETTERS, accurately, without erasures and in one color of ink.
If not complete, your application will not be processed.

INSURED PROSPECT INFORMATION: Attach a copy of valid ID or Passport and Migration Card.

First Last Name | Second Last Name | Married Name

First Name | Second Name

ID / Passport: | Date of Birth: DD MM YYYY | Age: | Sex: M ☐ F ☐

Foreign: No ☐ Y ☐ | Country of Origin: | Country of Residence:

Nationality/ies: | Years of Residence in Panama:

Civil Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ De Facto ☐ Widowed | Height: ☐ mts. ☐ inches | Weight: ☐ lbs. ☐ kgs.

Place of work: | Employee No.:

Economic Activity of the Company:

Employement Start Date: DD MM YY | Occupation: | Other Occupations:

Profession: | Job Description:

Province: | District / Township:

Housing Development: | Street: | Building:

Office Email: | Office Telephone:

Annual Approximate Income - Current Occupation B/.: | Annual Approximate Income - Other Occupations B/.:

Country/ies where you Pay Taxes on your Income: _____, _____, _____

PERSONAL INFORMATION / RESIDENTIAL:

Province: | District / Township:

Housing Development: | Street: | Building:

Apt. /House No.: | Residence Telephone: | Cell:

Personal Email:

DEPENDENT INFORMATION: ONLY IF APPLYING FOR INSURANCE. Attach a copy of valid ID or Passport and Migration Card.

Relationship	Name of dependent(s) entering the Policy	ID / Passport	Sex M/F	Date of Birth Day	Month	Year	Age	Height ☐ mts. ☐ inch	Weight ☐ lbs. ☐ kgs.
Spouse									
Son/Daughter									
Son/Daughter									
Son/Daughter									
Son/Daughter									

SPOUSE INFORMATION: ONLY IF APPLYING FOR INSURANCE. Attach a copy of valid ID or Passport and Migration Card.

Foreign: No ☐ Y ☐ | Country of Origin: | Nationality/ies: | Years of Residence in Panama:

Place of work: | Years Employeed:

Occupation: | Profession: | Cell:

Job Description:

Office Email: | Personal Email:

Province: | District / Township:

HEALTH QUESTIONNAIRE:

This declarations are important and part of your contract. Please answer all the questions accurately. Choose "Yes" or "No" to each question. Each time your answer is "Yes", specify disease, diagnosis, injury, deformity, medical procedures, treatments or surgeries, giving the exact date, duration, severity and the addresses and telephone numbers of the treating physicians and hospitals or clinics.

To the best of your knowledge, CHECK YES or NO, if any of the persons included in this request has had at any time o has been informed of having had or has been treated (highlight the relevant phrase) for any of the following conditions:

	PROSPECT		SPOUSE		CHILDREN	
	YES	NO	YES	NO	YES	NO
1- Cerebrovascular problems, migraines or headaches?	1 ☐	☐	☐	☐	☐	☐
2- Epilepsy, convulsions, seizure, blackout or unconsciousness?	2 ☐	☐	☐	☐	☐	☐
3- Hearing problems or poor hearing, eyesight, defective vision, cataracts, retinal detachment, corneal detachment or 3 eye disorders?	3 ☐	☐	☐	☐	☐	☐
4- Respiratory system problems, tuberculosis, asthma, emphysema, or rheumatic fever?	4 ☐	☐	☐	☐	☐	☐
5- Heart problems (cardiovascular), circulatory, chest pains, blood pressure (high or low), angina, phlebitis?	5 ☐	☐	☐	☐	☐	☐
6- Digestive system problems: stomach, esophagus, small/large intestine, liver, gall bladder, pancreas, colitis, hernia, diverticulitis, hemorrhoids, stomach ulcer, duodenal ulcer, dyspepsia, repeated indigestion, hepatitis A, B or C or any other discomfort of the rectum, intestines, stomach or ever had bleeding during bowel movements or stool?	6 ☐	☐	☐	☐	☐	☐
7- Kidney or bladder problems, kidney stones, kidney infection, urinary tract infection or blood in the urine?	7 ☐	☐	☐	☐	☐	☐
8- Spinal problems, back pain, multiple sclerosis or herniated discs?	8 ☐	☐	☐	☐	☐	☐
9- Joint diseases, lupus erythematosus, swelling, arthritis, gout or rheumatism?	9 ☐	☐	☐	☐	☐	☐
10- Cancer, cysts, tumor, leukemia, blood problems, diabetes, sickle cell anemia or hemorrhages, hemophilia or anemia?	10 ☐	☐	☐	☐	☐	☐
11- Have you suffered from skin disorders?	11 ☐	☐	☐	☐	☐	☐
12- Alteration of the thyroid gland: goiter, nodules, hypothyroidism, hyperthyroidism?	12 ☐	☐	☐	☐	☐	☐
13- Any congenital, hereditary, genetic or birth-acquired disease, injury or malformation?	13 ☐	☐	☐	☐	☐	☐
14- Have you been studied or diagnosed for any immunological disorder?	14 ☐	☐	☐	☐	☐	☐
15- Suffer from any type of allergy? Specify: _____	15 ☐	☐	☐	☐	☐	☐
16- Mental disorder, anxiety, depression, attention deficit disorder?	16 ☐	☐	☐	☐	☐	☐
17- Infectious diseases, toxoplasmosis, meningitis, herpes, dengue fever, chancroid, syphilis, gonorrhea, human papilloma virus, AIDS or sexually transmitted diseases?	17 ☐	☐	☐	☐	☐	☐
18- Do you use any type of drug or alcoholic beverage? If yes, specify type and frequency: _____	18 ☐	☐	☐	☐	☐	☐
19- For drug or alcohol-related causes, have you been sanctioned and/or received treatment? _____	19 ☐	☐	☐	☐	☐	☐
20- Have you lost or gained weight in the last twelve months? How many pounds? ☐☐☐ Why? _____	20 ☐	☐	☐	☐	☐	☐
21- Please list medications, vitamins, anabolics, hormones or other medications used by any of the applicants on a regular basis or if under medical treatment. Detail: _____	21 ☐	☐	☐	☐	☐	☐
22- Have you ever smoked a cigarette, cigar, pipe or used tobacco in any form?	22 ☐	☐	☐	☐	☐	☐
If yes, provide details: _____ Date: _____						
Do you currently smoke or have you smoked during the last 12 months?: Yes ☐ No ☐ How frequently? _____						
Do you use another product containing nicotine? _____ How frequently? _____						
Which one?						
23- Have you undergone x-ray, colonoscopy, endoscopy, cancer diagnostic studies, simple electrocardiogram or stress test?	23 ☐	☐	☐	☐	☐	☐
24- Have you undergone any type of surgery and/or hospitalization for illness, accident, aesthetics, obesity, blood transfusions, treatments or others? How many? ☐☐ Why? _____	24 ☐	☐	☐	☐	☐	☐
25- Have you been recommended for any future surgery, medical procedure or treatment?	25 ☐	☐	☐	☐	☐	☐
26- Is there any disease, illness, accident, physiological disorder or disability not mentioned in the previous questions?	26 ☐	☐	☐	☐	☐	☐
27- Do any of the applicants have a family history of cancer, diabetes, heart disease or hypertension?	27 ☐	☐	☐	☐	☐	☐

Applicant	Affected Relative	Disease	Age of Manifestation	Current State

FOR MEN: Insured Prospect, Spouse or Dependent Child

28- Have you had prostate alterations, varicocele, cryptorchid, testicular torsion or reproductive organs? or elevated PSA (Prostate Specific Antigen) result?

Yes ☐ No ☐ Physician: _____ Place of Care: _____

FOR WOMEN: Insured Prospect or Spouse

29- Are you pregnant? If yes, how many months are you? Yes ☐ No ☐

30- Miscarriages, premature deliveries or difficulty in your deliveries? Yes ☐ No ☐

31- Do you suffer from any gynecological disorder or disease? Yes ☐ No ☐

32- Have you had any tumors, fibroids, cysts or disease in: Yes ☐ No ☐
a) Breasts ☐ b) Ovaries ☐ c) Uterus ☐

33- Have you had vaginal bleeding? Yes ☐ No ☐

34- Are your menstrual periods regular? Yes ☐ No ☐

Date of your last menstruation: DD MM YY

35- Have you had any ultrasound, mammography or special tests? Yes ☐ No ☐

Results:

Date: DD MM YY

36- Name of Gynecologist:

Last Visit: /

Pap Smear Result. Classification/status

FOR CHILDREN: Insured Prospect or Dependents

37- Name of Pediatrician:

Date of Your Last Visit: DD MM YY

COVID-19: Applies to all Applicants.

1- In the last 30 days, have you had general symptoms such as: fever, muscle pain, malaise, headache, shortness of breath, or respiratory symptoms such as sore throat, cough, diarrhea or runny nose? Yes ☐ No ☐

2- Have tested positive on any of the COVID-19 tests, or are awaiting test results within the last 30 days? Yes ☐ No ☐

2.1- If so, have they fully recovered and returned to their normal activities? Yes ☐ No ☐

3- Did you ever require hospitalization in a ward, intensive care unit (ICU), or respiratory care unit (RCU) for observation or treatment of COVID-19? Yes ☐ No ☐

3.1- If so, please indicate whether you have any after-effects from COVID-19?

4- Have you received the COVID-19 vaccine? (If yes, please attach vaccination card) Yes ☐ No ☐

I agree with the Company establishing the insurability conditions that are in effect at the time of evaluation of this application.

IF YOU ANSWERED YES TO ANY OF THE PREVIOUS QUESTIONS, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Question Number	Name of Applicant and/or Dependent	Date of Last Care	Illness	Treating Physician or Hospital	Current Condition Confirm if operated or hospitalized
		/ /			
		/ /			
		/ /			
		/ /			

LIFESTYLE: Applies to all Applicants.

1- With whom does the Insured Prospect reside?

1.2- If married or de facto, what is the full name of your partner?

1.3- What is the age and occupation of your partner?

1.4- If your partner or spouse does not have insurance, why is this?

1.5- Do you have pets? Which? Yes ☐ No ☐

2- Have any of you traveled more than once every 2 months or lived outside your country of residence during the last year, or do you intend to do so during the next year? Yes ☐ No ☐

2.1- Who? Indicate date:

3- Do you practice any eating style? Yes ☐ No ☐ Which?

Who? Since when?

4- Do any of you have a pilot's license? Have you flown or plan to fly any aircraft or do you fly in other than licensed commercial airlines? If yes, please complete the aviation questionnaire. Yes ☐ No ☐

5- Do you practice any sport or activity? Yes ☐ No ☐

Who?

Which?

6- Do you participate or plan to participate in automotive races, motorcycles, parachuting, scuba diving or any other activity or high risk sport? Please complete de applicable questionnaire. Detail: Yes ☐ No ☐

7- Have you ever been convicted, prosecuted or investigated in any country for any violation of law? Please specify: Yes ☐ No ☐

ADDITIONAL QUESTIONS: Applies to all Applicants.

1- Were any insurable family members left out? Yes ☐ No ☐ Who:

2- Is anyone residing, studying or about to leave for a period longer than two months abroad? Yes ☐ No ☐ Name:

Indicate Country: State: University:

3- Do you have other hospitalization insurance or do you have an application pending with this or any other company? Policy No./Request:

Company: Who?

4- Have you been declined, postponed, surcharged or modified on a Health, Life or Personal Accident Application or policy with this or any other company?

Name:

CONTRACTING PARTY: Complete only if different from the Prospect.

LEGAL PERSON: Relation to the Prospect:

Company Name - Attach the Single Regulated Entity Form and required documents.

NATURAL PERSON: Attach a copy of valid ID or Passport and Migration Card.

First Last Name | Second Last Name | Married Name | Name

ID / Passport: Date of Birth: DD MM YYYY Age: Sex: M F

Foreign: Yes No Country of Origin: Years of Residence in Panama:

Nationality/ies:

Province: District / Township:

Housing Development: Street: Building:

Apt. /House No.: Residence Telephone: Cell:

Personal Email: Zone:

Place of work: Employee No.:

Economic Activity of the Company:

Employement Start Date: DD MM YY Occupation: Other Occupations:

Profession: Job Description:

Province: District / Township:

Housing Development: Street: Building:

Office Email: Office Telephone:

Annual Approximate Income - Current Occupation B/.: Annual Approximate Income - Other Occupations B/.:

Country/ies where you Pay Taxes on your Income: , ,

RESPONSIBLE FOR PAYMENT: Complete only if different from the Prospect.

LEGAL PERSON: Relation to the Prospect:

Company Name - Attach the Single Regulated Entity Form and required documents.

NATURAL PERSON: Attach a copy of valid ID or Passport and Migration Card.

First Last Name | Second Last Name | Married Name | Name

ID / Passport: Date of Birth: DD MM YYYY Age: Sex: M F

Foreign: Yes No Country of Origin: Years of Residence in Panama:

Nationality/ies:

Province: District / Township:

Housing Development: Street: Building:

Apt. /House No.: Residence Telephone: Cell:

Personal Email: Zone:

Place of work: Employee No.:

Economic Activity of the Company:

Employement Start Date: DD MM YY Occupation: Other Occupations:

Profession: Job Description:

Province: District / Township:

Housing Development: Street: Building:

Office Email: Office Telephone:

Annual Approx Income - Current Occupation B/.: Annual Approx Income - Other Occupations B/.:

Country/ies where you Pay Taxes on your Income: , ,

PLAN CHOSEN: Type of Policy: ☐ Individual ☐ Group Policy No.: Plan:

☐ MEDIRED: PLAN

☐ XTREME CARE: PLAN DEDUCTIBLE B/.

☐ INTERNATIONAL HEALTH PLAN: PLAN DEDUCTIBLE B/. PREMIUM ENDORSEMENT: Y ☐ No ☐

For IHP III and Ultimate, complete Annex A

PAYMENT METHOD:

- ☐ Credit Card
- ☐ Bank Discount via ACH (attach form)
- ☐ Voluntary/Broker/Window/Online Banking/Yappy
- ☐ Company

PAYMENT FREQUENCY:

- ☐ Monthly
- ☐ Semi-annual
- ☐ Quarterly
- ☐ Anual

PREMIUM: Per Payment Frequency

Premium	B/.
Tax 5%	B/.
TOTAL	B/.

Are the total annual premiums that You, the Prospect, Contracting Party or Person Responsible for Payment, pay equal or exceed B/. 10,000.00?: Yes ☐ No ☐

If your answer is yes, attach the applicable single regulated subject form for the Prospect, Contracting Party or Person Responsible for Payment.

PAYMENT AUTHORIZATION FOR CREDIT CARD: Attach a photocopy of the payer's identity card and legible credit card (front).

Payer: ☐ Prospect ☐ Contracting Party ☐ Responsible for Payment

Bank: Type: ☐ Visa ☐ Master Card ☐ AMEX

Card N°: Expiration: / As of: / Date of charge:

I agree that if the premium varies, the discount will be adjusted. This authorization shall remain in force and may only be cancelled by me by means of written notification to Cía. Internacional de Seguros, S.A., which shall become effective once Cía. Internacional de Seguros has received the new form of payment by automatic conduit. Likewise, I will notify the change of the expiration date of the card fifteen days in advance with each renewal of the same.

Signature of Cardholder | Identification Card | / / Date

CLAIM REIMBURSEMENT AUTHORIZATION: Bank information of the Prospect or Contracting Party (Natural Person)

Reimbursement: ☐ Prospect ☐ Contracting Party (in the case of minors who are prospects)

Bank: Type of Account: Savings ☐ Checking ☐

Name of Account: Account N°: (no hyphens)

I confirm that the above account is registered in our name and that the undersigned has the corresponding authorization from the prospect or from the policy and the bank to authorize it to be credited. In consideration of this service, I further agree that, should any such payment order be disregarded by THE BANK, without cause or inadvertently, COMPAÑÍA INTERNACIONAL DE SEGUROS, S.A. (THE COMPANY) shall have no liability whatsoever. This authorization shall remain in effect until: 1. THE COMPANY receives written notice of termination signed by the person(s) managing the account; 2. The account is closed; and/or, 3. The policy or certificate is cancelled.

POLITICALLY EXPOSED PERSONS: Attach the documents required.

Nationals or foreigners who perform prominent public functions at a high level or with command and jurisdiction in a State, such as heads of States or of a government, high-profile politicians, high-ranking government, high-rank judicial or military officials, senior executives of state-owned companies or corporations, public officials holding postions by popular vote, among others who exercise decision-making in public entities; persons performing or entrusted with important functions by an international organization, such as members of senior management, i.e. directors, deputy directors and members of the board of directors or equivalent functions.

Is the Prospect a politically exposed person? Yes ☐ No ☐ Current or previous position:

Is the Contracting Party a politically exposed person? Yes ☐ No ☐ Current or previous position:

Is the Responsible for Payment a politically exposed person? Yes ☐ No ☐ Current or previous position:

ANNEX A - BENEFIT OF HEALTH INSURANCE

REGISTRY OF BENEFICIARIES

1. Insured Prospect:

Beneficiaries	Relationship	%

Contingent Beneficiary:

2. Dependent Spouse:

Beneficiaries	Relationship	%

Contingent Beneficiary:

3. Dependent Children:

The beneficiary of any insured child shall be the principal insured or, in the absence thereof, the spouse; provided that the latter was the father or mother of the insured.

Contingent Beneficiary of children:

If one of the beneficiaries is not alive or does not wish or is unable to receive his/her share, such share shall increase that of the other principal beneficiary(ies) in equal parts. Only in the event that no principal beneficiary is alive, willing or able to receive the sum insured may the contingent beneficiary(ies), in the percentages indicated above (if any), receive the payment. If one of the contingent beneficiaries is not living or is unwilling or unable to receive his share, his share shall be increased by that of the other contingent beneficiary(ies) in equal shares, unless otherwise clearly indicated in writing by the insured.

Any benefit corresponding to a minor designated as beneficiary in this Policy will be paid to

Identification Card N° , and in his absence

Identification Card N° whom I have instructed on the manner in which they shall dispose of

of the monies received from the Company, without such person(s) being considered as beneficiary(ies) of this insurance.

I understand and accept that the Company assumes no responsibility whatsoever, nor does it have the obligation to oversee and/or supervise the administration or the use that the person(s) designated above may make of the indemnity resulting from the life insurance coverage contracted.

In case of doubt as to whom the payment should be made, the Company reserves the right to deposit the proceeds of the indemnity before a competent court, so that the judicial authority may determine who should receive it, the Company being released from its obligations to any beneficiary claiming the right to the indemnity, from the moment the judicial consignment is made.

Name of Prospect		**Name of Spouse**	
Signature		Signature	
Identification		Identification	
Date	/ /	Date	/ /

DECLARATION: In my name and on behalf of the persons included in this application, I declare that the information herein is true and accurate, that there are no circumstances other than those declared herein that may aggravate the risk and that I have not omitted, misrepresented, or concealed: habits, procedures, diagnoses, pathological background, health problems, disorders, diseases, illnesses, ailments, physiological disorders, disabilities, accidents, injuries, discomfort or any ailment suffered. I agree that this application shall form the basis for the issuance of the Policy and shall form an integral part thereof. I agree that the Policy shall be declared null and void by COMPAÑÍA INTERNACIONAL DE SEGUROS, S.A. (THE COMPANY), in case of inaccuracy, reticence, false or inaccurate statement on my part, about circumstances which if known by THE COMPANY would have caused it to withdraw from the Contract, or induced it to stipulate more onerous conditions.

TERM AND CONDITIONS OF THIS APPLICATION: The insurance shall take effect conditionally from the date on which COMPAÑÍA INTERNACIONAL DE SEGUROS, S.A. (THE COMPANY) approves the respective application. THE COMPANY shall have 30 days from the date of receipt of the Application to study and decide the action to be taken thereon, and if within such period the Prospect does not receive notice of rejection of his application, he shall consider it as accepted by the Company, except in cases where the COMPANY is awaiting: any medical evidence, information on the state of health of the Applicant or any of his dependents, signature endorsement, etc. If the COMPANY refuses to accept the application and not issue the policy, it shall not incur any obligation by virtue of such application. In such case, the COMPANY shall refund to the Applicant the amount paid as down payment to such application.

CONFIDENTIALITY OF INFORMATION: I hereby declare that, in full knowledge of Law No. 68 of November 20, 2003, Law No. 40 of August 14, 2018, and other related regulations, I voluntarily, freely, spontaneously, and irrevocably authorize of November 20, 2003, Law No. 40 of August 14, 2018, and other related regulations, I hereby voluntarily, freely, spontaneously and irrevocably authorize COMPAÑÍA INTERNACIONAL DE SEGUROS, S.A. (THE COMPANY), to request, collect and obtain from any physician, second opinion physician or referred by THE COMPANY, health professional, hospital, clinic, laboratory, pharmacy, diagnostic center, Caja del Seguro Social, Hospital Santo Tomas, Ministry of Health, and any other medical or medically related facility, whether private or governmental, licensed as such, insurance company or group insurance policy holder, insurer or employer, medical information bureau or other organization, institution or person having any health information about me, my spouse or dependent children proposed to be insured, whether in the Republic of Panama or abroad. This authorization includes providing such information to THE COMPANY, representatives and Reinsurers, whether by means of reports, photocopies of tests, images, diagnoses, statements, clinical records or professional records in their possession; I hereby expressly waive all provisions of law which prohibit any medical provider or other person who has assisted or recognized me, or who may hereafter assist or recognize me, from disclosing any knowledge or information acquired even after my death without consequence to them or to the insurer who, by signing this application, I hereby release from all liability for furnishing or collecting the information furnished by the foregoing persons and entities. Additionally, I authorize the broker designated in my policy or the contracting party to manage, receive and have access to all the information related to my claims, pre-authorizations and clinical history, as well as the COMPANY to have access to the information and share it with other providers and professionals it deems convenient for the evaluation of the case.

In the same way, in compliance with Law 81 of 2019 (Regulated by Executive Decree 285 of May 28, 2021), in accordance with Law 12 of 2012, I declare that I accept and expressly authorize THE COMPANY to collect, store and transfer personal and sensitive data, acquired or obtained, regarding the contracting party, insured, dependents and responsible for payment. I expressly authorize THE COMPANY to use the data obtained and those to which THE COMPANY has had access due to the execution of the Insurance Contract so that THE COMPANY, at its discretion, may use and transfer them within the needs of its commercial activity, for purposes related to the products, policies, benefits and/or services contemplated herein, and any others that THE COMPANY may deem convenient; including, all its subsidiaries, affiliates and branches, reinsurers, insurance companies, health centers or clinics, health professionals, and any other advisors or professionals that at the discretion of THE COMPANY, may be necessary and convenient for the evaluation of a case, according to the operations of THE COMPANY.

I declare that the information contained in this Application is true, complete and provides reliable and updated information on all the aspects about which questions have been asked and that all my activities are carried out within the legal norms and that the resources used for the payment of the insurance mentioned above come from the following sources.

Name of Prospect _____

Signature _____

ID _____ Date / /

Name of Spouse _____

Signature _____

ID _____ Date / /

Name of Dependent
of legal age (18 years old) _____

Signature _____

ID _____ Date / /

Name of Dependent
of legal age (18 years old) _____

Signature _____

ID _____ Date / /

Name of Dependent
of legal age (18 years old) _____

Signature _____

ID _____ Date / /

Name of Dependent
of legal age (18 years old) _____

Signature _____

ID _____ Date / /

Name of Contracting Party _____

Signature _____

ID _____ Date / /

Name of
Responsible for Payment _____

Signature _____

ID _____ Date / /

BROKER INFORMATION: I certify that the information contained in this application has been answered to the best of my knowledge and belief, so that no false, altered or incomplete information is being provided.

1- Do you know the Prospect and/or dependents? Yes ☐ No ☐ Who do you know and how long have you known him/her? _____

2- Do you know that the Prospect and Dependents over 18 completed and signed this application? Yes ☐ No ☐

3- Are you aware of any facts or contradictions with the answers of Prospect or Dependents? _____

4- Has any Life, Personal Accident or Health insurance ever been declined, deferred, modified or surcharged to the Prospect and/or his/her dependents? If yes, please specify: Yes ☐ No ☐

_____

Name or Company Name: _____ Telephone: ☐☐☐☐☐☐☐☐☐☐

print

E-mail: _____

Signature of Broker: _____ Licencia Number: _____ / / Date

FOR COMPANY USE:

Evaluation: **Approved** ☐ **Declined** ☐ **Surcharge** ☐ **%:** _____ Reason: _____

Pre-Exisiting Conditions: **Temporary** ☐ **Permanent** ☐ **Duration** From: ☐☐ ☐☐ ☐☐ (DD MM YY) Until: ☐☐ ☐☐ ☐☐ (DD MM YY)

Exclusions: _____

_____

Name and Last Name of Subscriber _____ Signature _____ / / Date

Approval:

Name _____ Signature _____ / / Date

MEDICAL EVALUATION:

_____

_____

_____

_____

Physician: _____ _____ / / Name Signature Date

OBSERVATIONS:

_____

_____

_____

PAYMENT STAMP

STAMP OF RECEIVED