Prevem seguros®

Bar code

Notice of accident or Illness

Instructions:

1. This form shall be filled out in print hand writing. Signed by the insured policy holder and affected insured.
2. It shall be entirely filled out and complete and detailed information shall be provided.
3. It shall be void if it shows erasures or corrections.
4. Providing requested data below does not represent an obligation to admit claim validity by Prevem Seguros S.A. de C.V. nor waiver of its rights reserved under the agreement. No subsequent changes shall be accepted to the statements made by the insured herein.

A. General Data - Affected insured data

Paternal Las Name, Maternal Lasta Name and Fisrt Name of Insured Policy Holder: _____

Paternal Las Name, Maternal Lasta Name and Fisrt Name of Affected Insured: _____

Date of Birth	Sex	Relationship of Policy Holder	Contac Telephone number	Citizenchip	Contact Email
MM/DD/YYYY	M☐ F☐				

Street	Outsid N°	Indor N°

Area	Zip Code	Delegation/Municipality

City		State		POLICY	

Reimbursement ☐ Direct payment ☐ Surgery-treatment scheduling ☐ Accident ☐ Disease ☐ Pregnancy ☐

C. Questions related to illness or accident being declared

Date when the Accident Occurred or Appearance of first Symptoms of Disease and grounds for this claim: MM/DD/YYYY

Point out type ofAtteratlonsand/or Symptoms you presented:	**Point out Diagnosis giving to your claim (inclicated by your attending doctor)**

Should it be Accident, describe How and where did it occur?

Was any autflorlty aware of the Accident? YES ☐ NO ☐ In case of Car Accident, do you have Auto Insurance? YES ☐ NO ☐

If your answer was yes, please complete the following information

Name of the Insurace Corripany	Policy No.	Third Party Company	Have you lieen hospitalized?	Days of stay	Which Hospital were you in?
			YES ☐ NO☐		

Have you submitted previous expenses for this Condition or Accident in this or any other company? YES ☐ NO☐

If your answer was yes, please complete the following information:

Claim N°		Company		Claim date:	MM/DD/YYYY

Do you currently have other Medical Experince Insurance? YES ☐ NO☐ Mention which one

D. Data of Consulted physician(s)

Name of Attending Physician:_____	Specialty _____	Hospital Name: _____
Physician's office telephone number: _____	Cell phone _____	Telephone number: _____
Email: _____	Address: _____	
Starting attention Date with this physician: MM/DD/YYYY	Hospitalization Date: MM/DD/YYYY	
Name and telephone of Family doctor:		

FSIN-002

Tecoyotitla 412 edificlo arena! piso 3 Col. Ex hacienda de Guadalupe Chimalistac C.P. 01050 Mexico, D.F. Tel: 91•78•26•00/01•800•2 PREVEM (77•38•36) www.prevemseguros.mx

E. Payment Instructions

I hereby request and authorize Prevem Seguros S.A. de C.V. to make any payment that has to be covered to me, derived from the insurance agreement entered into with this insurance company. Such payment shall be carried out according to the following information:

Check	☐		
Wire transfer	☐	Bank:	CLABE:[1]

Note: Should this payment for current claim lawful, it shall be made to the insured policy holder and the specified bank account must have been registred to his/her name.

Upon "Indemnification" payment, "Insured" agrees that all benefits being requested to PREVEM Seguros, S.A. de C.V. will be covered, regarding the previously mentioned claim.

Parties agree that upon making the corresponding payment, either: (i) by check, and as of delivery thereof, it is the "Insured's" responsibility the check "collection" or (ii) by wire transfer upon delivery of payment proof, such instrument shall be considered as a final settlement receipt. Consequently, the "Insured" states under penalty of perjury, that once payment is received, he/she shall not reserve any present or future right nor to take any legal action, whether of civil, criminal, labor, fiscal, administrative, labor nature, or any other kind or type, to be filed against PREVEM Seguros, S.A. de C.V., or its employees, attorneys at law, legal representatives, workers, service providers, officers, subsidiaries, nor by any fact derived from the specified "Claim" or from the "Policy" concerning to filed claim, granting hereupon the broadest settlement in compliance with law, since he/she has satisfied his/her claim and no amount is owed to him/her.

F. Documents and signatures

1. Copy of District Attorney legal actions or attention received from the institution (in case of a public road accident).
2. Interpretation of imaging studies or clinical studies.
3. Copy of official identification of affected insured (IFE2, passport and, in case of children under 5 years old, birth certificate).
4. Receipts of expenses meeting fiscal requirements and statements of account, (copies, provisional receipts, etc. shall be void)
5. The corresponding medical reports by each attending physician and their participation in the event must be completed.

Authorization

You are hereby informed that inaccurate or false statement provided in this form releases Prevem Seguros S.A. de C.V. from any liability. I hereby authorize physicians who attended me or examined me, to hospitals, clinics, sanatoriums, laboratories and/or health institutions, to which I had come for treatment and/or diagnosis of any illness, accident, or injury, and/or to judicial or administrative authorities, even there being no judicial or administrative order, who have had knowledge of my case, to provide to Prevem Seguros S.A. de C.V. all information regarding my personal pathological background, clinical history, medical indications, laboratory and clinical studies' results and any other information contained in my clinical file, which may be required at any time that Prevem Seguros S.A. de C.V. considers appropriate, even after my death.

By means of this authorization, I release from any liability arising from medical secrecy to persons responsible for providing required information, likewise I authorize the insurance companies to which I have previously requested execution of any contract or requested for insurance to provide Prevem Seguros S.A. de C.V. the relevant information held by them and, in turn, Prevem Seguros S.A. de C.V. must provide to any other insurance company in the market the information it shall require and arising under this document and from others that are within their own knowledge.

_____	_____
Name and Signature of Policy Holder or Contracting Party	Affected's name and signature (In case of being a minor signature of either parent)

Date MM/DD/YYYY Place _____

1 From Spanish acronym of Clave Bancaria Estandarizada - Standardized Banking Code.
2 from Spañish acronym of Instituto Federal Electoral - Federal Electoral Institute.

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