GLOBAL HEALTH PLANS

INSURANCE APPLICATION FOR INDIVIDUAL MAJOR MEDICAL EXPENSES

BUPA GUATEMALA

HOW TO USE THIS FORM

In order to help you fill out this form, we have divided it into clearly numbered sections. To avoid the continuous repetition of names, these icons AT 1 2 3 4 represent the person that you are describing in the form.

When you see AT please fill in the information pertaining to the Policyholder and/or contracting party. Icons 1 to 4 correspond to the dependents to be included in the policy.

IMPORTANT INFORMATION

PLEASE FILL OUT IN CLEAR HANDWRITING, USING BLACK INK AND CAPITAL LETTERS.

Once completed, please scan and send your form to: ServicioGuatemala@bupalatinamerica.com. In order for the policy to be issued, the signed original and your identification documentation must be received in our offices at 5ª Avenida 5-55, Zona 14, Europlaza World Business Center, Torre III, Nivel 11, Oficina 1103, Ciudad de Guatemala.

Make sure you provide us with full and precise information for each of the persons to be included.

All sections must be completed by the Policyholder and/or contracting party.

Once you complete this form and before signing it, read it thoroughly and make sure the information is correct and complete. The evaluation and issuing process will only begin if the application has been completed in its entirety and does not show alterations or crossed-out information, and your documentation has been received.

We hope to welcome you soon as a Bupa Global insured. Bupa or Bupa Global refer to Bupa Guatemala, Compañía de Seguros, S.A.

FOR **NEW INSUREDS**

Please complete sections 2 to 11 and section 14.
Read, sign and date the Consent in section 12.
The insurance broker must fill out and sign section 13.

FOR **CURRENT INSUREDS**

You may request changes to this plan by completing this form. Please read, sign and date the Consent in section 12.

Changing your contact information:
Please notify us of any changes in your contact information to ensure you receive important communications.

- Complete sections 1 to 4, if applicable.
- Complete section 10, if applicable.
- Read, sign and date the Consent in section 12.

Adding a new person to your plan:
- Complete sections 1, and 6 to 8.
- Complete sections 10 and 11, if applicable.
- Read, sign and date the Consent in section 12.

Changing coverage (only within Global Health Plans):
- Complete sections 1, and 7 to 9.
- Read, sign and date the Consent in section 12.

Changing your payment method:
- Complete sections 1 and 14.
- Read, sign and date the Consent in section 12.

Bupa Guatemala, Compañía de Seguros, S.A. reserves the right to contact the applicant if any question is not explained in detail or if additional information is required. This application is not valid if it has deletions, amendments or if fields have been left unanswered.

GLOBAL HEALTH PLANS INSURANCE APPLICATION FOR INDIVIDUAL MAJOR MEDICAL EXPENSES

1302

This application must be completed by new insureds or current Bupa Global insureds.

DO NOT FILL OUT THIS FORM. THIS DOCUMENT IS FOR REFERENCE ONLY. PLEASE FILL OUT THE SPANISH VERSION.

NEW POLICY ☐	ADDITIONAL DEPENDENT ☐	CHANGE ☐
Requested date of coverage	DD/MM/YYYY	

1 DETAILS OF CURRENT POLICY (AT)

Policy number		Client number (for company use only)	

2 POLICYHOLDER INFORMATION (AT)

Marital status*		Male ☐ Female ☐	Weight		Kg ☐ Lbs ☐	Height		Mts.
Names	FIRST NAME		MIDDLE NAME		OTHER NAMES			
Last names	LAST NAME		MAIDEN NAME		MARRIED NAME			
Date of birth	DD/MM/YYYY		Nationality					
Country of birth								
Occupation or profession			NIT					
ID document No.			DPI ☐		Passport ☐			

* Marital status: please write **S** for single or **C** for married.

Politically Exposed Person (PEP): Person who currently hold or has held public office in Guatemala or any other country, a prominent position in an international organization, leaders of national or foreign political parties	Is the applicant a PEP?	Yes ☐ No ☐
	Is the applicant a relative of a PEP?	Yes ☐ No ☐
	Is the applicant an associate of a PEP?	Yes ☐ No ☐

POLICYHOLDER'S CONTACT INFORMATION

Address			
Zone		Municipality	
Department		City	
Postal code		Country	Years at this location
Telephone number		Cellphone number	
E-mail			

Residence and citizenship status: Are you a permanent resident or citizen of the USA? Yes ☐ No ☐
If "Yes", are you currently residing or have you resided in the USA for more than 6 months in one year? Yes ☐ No ☐

Do all dependents live at the same address above? Yes ☐ No ☐ If "No", please explain:

3 CONTRACTING PARTY INFORMATION (INDIVIDUAL) (AT)

Complete if different from the Policyholder			Marital status*		Male ☐ Female ☐
Names	FIRST NAME	MIDDLE NAME		OTHER NAMES	
Last names	LAST NAME	MAIDEN NAME		MARRIED NAME	
Date of birth	DD/MM/YYYY	Nationality			
Country of birth					
Occupation or profession		NIT			
ID document No.		DPI ☐		Passport ☐	

* Marital status: please write **S** for single or **C** for married.

PEP Information (a person who currently holds or previously held public office in Guatemala or any other country, a prominent position in an international organization, personalities of national or international political parties.	Is the applicant a (PEP)?	Yes ☐ No ☐
	Is the applicant a relative of a PEP?	Yes ☐ No ☐
	Is the applicant an associate of a PEP?	Yes ☐ No ☐

CONTRACTING PARTY'S CONTACT INFORMATION (INDIVIDUAL)

Complete if different from the Policyholder

Address			
Zone		Municipality	
Department		City	
Postal code		Country	
Telephone number		Cellphone number	
E-mail			

4 CONTRACTING PARTY'S INFORMATION (LEGAL ENTITY) AT

Name			
Incorporation date		Registration number	
Name of legal representative			
Commercial activity		NIT	
Address			
Municipality		Department	
City		Postal code	
Country			
Telephone number		E-mail	

5 PAPERLESS CUSTOMER SIGN UP AT

At Bupa we strive to protect the environment. This is why we encourage you to choose paperless services. By doing so, the insured accepts receiving all documents and correspondence through www.bupasalud.com. Please confirm that you have provided your valid E-mail for contact. This means you and your dependents will not receive printed copies. In case you need printed documents, please check here. ☐

6 ADDITIONAL POLICY MEMBERS

Marital status*		Male ☐ Female ☐	Weight		Kg ☐ Lbs ☐	Height		Mts. 1
Names	FIRST NAME		MIDDLE NAME		OTHER NAMES			
Last names	LAST NAME		MAIDEN NAME		MARRIED NAME			
Date of birth	DD/MM/YYYY		Nationality					
Country of birth								
Occupation or profession			NIT					
ID document No.			DPI ☐		Passport ☐			

* Marital status: please write **S** for single or **C** for married.
In the Occupation or profession field, please indicate if the dependent is a student.

If this is a newborn addition, please answer the following question: Was the baby born as a result of a fertility treatment, is adopted, or was born from a surrogate mother? Yes ☐ No ☐

Marital status*		Male ☐ Female ☐	Weight		Kg ☐ Lbs ☐	Height		Mts. 2
Names	FIRST NAME		MIDDLE NAME		OTHER NAMES			
Last names	LAST NAME		MAIDEN NAME		MARRIED NAME			
Date of birth	DD/MM/YYYY		Nationality					
Country of birth								
Occupation or profession			NIT					
ID document No.			DPI ☐		Passport ☐			

* Marital status: please write **S** for single or **C** for married.
In the Occupation or profession field, please indicate if the dependent is a student.

If this is a newborn addition, please answer the following question: Was the baby born as a result of a fertility treatment, is adopted, or was born from a surrogate mother? Yes ☐ No ☐

6 ADDITIONAL POLICY MEMBERS (CONTINUED)

Marital status*		Male ☐ Female ☐	Weight		Kg ☐ Lbs ☐	Height		Mts. 3
Names	FIRST NAME		MIDDLE NAME			OTHER NAMES		
Last names	LAST NAME		MAIDEN NAME			MARRIED NAME		
Date of birth	DD/MM/YYYY		Nationality					
Country of birth								
Occupation or profession			NIT					
ID document No.			DPI ☐	Passport ☐				

* Marital status: please write **S** for single or **C** for married.
In the Occupation or profession field, please indicate if the dependent is a student.

If this is a newborn addition, please answer the following question: Was the baby born as a result of a fertility treatment, is adopted, or was born from a surrogate mother? Yes ☐ No ☐

Marital status*		Male ☐ Female ☐	Weight		Kg ☐ Lbs ☐	Height		Mts. 4
Names	FIRST NAME		MIDDLE NAME			OTHER NAMES		
Last names	LAST NAME		MAIDEN NAME			MARRIED NAME		
Date of birth	DD/MM/YYYY		Nationality					
Country of birth								
Occupation or profession			NIT					
ID document No.			DPI ☐	Passport ☐				

* Marital status: please write **S** for single or **C** for married.
In the Occupation or profession field, please indicate if the dependent is a student.

If this is a newborn addition, please answer the following question: Was the baby born as a result of a fertility treatment, is adopted, or was born from a surrogate mother? Yes ☐ No ☐

If any of these people has a different address, or if you wish to add more people, please check here. ☐
Note: All applicants 65 years of age or older must submit a Medical Statement form and attach the results of the requested tests.

7 MEDICAL QUESTIONNAIRE

This section must be completed with the medical information of **all policy members**, considering all current and previous conditions. Please make sure you declare everything about any condition and symptoms, known or suspected, even if you haven't yet sought medical care. The medical conditions listed are just examples of illnesses or conditions grouped according to body system, but do not limit or exclude other related conditions. If you are a current Bupa Global policyholder and would like to change your plan, you must also include your health information. This information will be reviewed by our underwriting team, who will evaluate the terms of your plan.

1	Eye, ear, nose, and throat disorders or dental problems like cataracts, glaucoma, retinopathy, visual impairment, deafness, recurrent ear infections, tonsillitis, dental infections, cavities, wisdom teeth problems or gingivitis, among others.	Yes ☐ No ☐
	Name of applicant(s)	
2	Cardiovascular or circulatory system disorders like hypertension, high cholesterol, angina pectoris, arrhythmia, aneurysms, varicose veins, or deep vein thrombosis, among others.	Yes ☐ No ☐
	Name of applicant(s)	
3	Endocrine (glandular) or metabolic disorders like diabetes (Type 1 or Type 2), thyroid problems, obesity, or Cushing's syndrome, among others.	Yes ☐ No ☐
	Name of applicant(s)	
4	Respiratory or pulmonary disorders like asthma, chronic obstructive pulmonary disease (COPD), pneumonia, bronchitis, tuberculosis, or allergies (including hay fever and anaphylaxis), among others.	Yes ☐ No ☐
	Name of applicant(s)	
5	Disorders of the esophagus, stomach, intestines, liver, pancreas, spleen or gall bladder like reflux, gastritis, esophagitis, Barrett's esophagus, ulcers, irritable bowel syndrome, chronic ulcerative colitis, diverticulitis, hemorrhoids, pancreatitis, hepatitis, cirrhosis, gall stones, or hernias, among others.	Yes ☐ No ☐
	Name of applicant(s)	

7 MEDICAL QUESTIONNAIRE (CONTINUED)

6	Kidney or urinary disorders like kidney stones, renal insufficiency, recurrent urinary tract infections (UTI), or incontinence, among others.	Yes ☐ No ☐
	Name of applicant(s)	
7	Muscle or skeletal disorders like arthritis, lumbago, spinal column ailments, neck/shoulder ailments, fractures, sprains, osteoporosis, gout, knee ailments, or cartilage and ligament problems, among others.	Yes ☐ No ☐
	Name of applicant(s)	
8	Blood, infectious, or immunodeficiency disorders like abnormal blood test results, anemia, hepatitis, HIV/AIDS, malaria, systemic lupus erythematous, idiopathic thrombocytopenic purpura (ITP), thalassemia, or any autoimmune disorder, among others.	Yes ☐ No ☐
	Name of applicant(s)	
9	Cancer, tumours of any type, or pre-cancerous conditions like polyps, benign growths, breast nodules, cysts, or lymphomas, among others.	Yes ☐ No ☐
	Name of applicant(s)	
10	Skin disorders like eczema, dermatitis, rashes, psoriasis, acne, cysts, moles, or allergic conditions, among others.	Yes ☐ No ☐
	Name of applicant(s)	
11	Brain or nervous system disorders like dementia, migraine, frequent headaches, paralysis, multiple sclerosis, epilepsy/convulsive seizures, neuralgia (including sciatica herpes zoster or shingles) or meningitis, among others.	Yes ☐ No ☐
	Name of applicant(s)	
12	Psychiatric or psychological disorders like schizophrenia, eating disorders, depression, attention deficit disorder (ADD), anxiety or drug/alcohol dependency, among others.	Yes ☐ No ☐
	Name of applicant(s)	
13	Congenital or hereditary disorders of any type.	Yes ☐ No ☐
	Name of applicant(s)	
14	Cosmetic surgery, like breast augmentation or reduction, or rhinoplasty, among others.	Yes ☐ No ☐
	Name of applicant(s)	
15	Are you currently under medical treatment and/or rehabilitation?	Yes ☐ No ☐
	Name of applicant(s)	
16	Are you or any of the applicants taking any medication or have been prescribed any medication?	Yes ☐ No ☐
	Name of applicant(s)	
17	Any other illness, disorder, injury, accident or pending surgery/hospitalization not previously mentioned above?	Yes ☐ No ☐
	Name of applicant(s)	
18	QUESTIONS FOR FEMALE APPLICANTS ONLY	
a	Are you pregnant?	Yes ☐ No ☐
	Name of applicant(s)	
b	Have you had any pregnancy complications? Preeclampsia ☐ Eclampsia ☐	Yes ☐ No ☐
	Name of applicant(s)	
c	Have you had an ectopic pregnancy? Date: DD/MM/YYYY	Yes ☐ No ☐
	Name of applicant(s)	
d	Have you had a dilation and curettage (D&C)? Date: DD/MM/YYYY Type:	Yes ☐ No ☐
	Name of applicant(s)	
e	Have you had an abortion? Date: DD/MM/YYYY Cause:	Yes ☐ No ☐
	Name of applicant(s)	

7 MEDICAL QUESTIONNAIRE (CONTINUED)

f	Have you had a cesarean section? Date:	DD/MM/YYYY	Cause:		Yes ☐ No ☐
	Name of applicant(s)				
g	Have you had any fertility/ infertility treatment? Date:	DD/MM/YYYY	Cause:		Yes ☐ No ☐
	Name of applicant(s)				
h	Have you had any sexually transmitted diseases or disorders of the female reproductive system (ovaries, uterus or mammary glands) like the human papillomavirus (HPV) infection, pelvic inflammatory disease, heavy or irregular menstruation, fibroids, endometriosis, infertility, abnormal cytology, polycystic ovaries, etc.?				Yes ☐ No ☐
	Name of applicant(s)				
19	QUESTION FOR MALE APPLICANTS ONLY				
a	Have you had any sexually transmitted diseases or disorders of the male reproductive system like prostatitis, benign prostatic hyperplasia (enlarged prostate), infertility, testicular disorders, and mammary glands, among others?				Yes ☐ No ☐
	Name of applicant(s)				

ADDITIONAL INFORMATION

Complete this section if you responded affirmatively to any of the medical questions from 1 to 19. Please include any detail even when you are not sure of its importance.

(a) Describe illness or medical condition, indicating affected body area (e.g.: right leg, left eye).

(b) Describe type of treatment (medical, surgical, rehabilitation) and the result (ongoing, completed, in recovery, recurring, probable repetition).

(c) For pharmacotherapy, include medicine name, beginning of treatment, amount, and frequency.

Please check if you used an additional sheet of paper to continue. ☐

Name of applicant					
Question No.		Illness or medical condition			
Date of first symptom	DD/MM/YYYY	Beginning of treatment	DD/MM/YYYY	End of treatment	DD/MM/YYYY
Treatment (b) (c)					
Name of applicant					
Question No.		Illness or medical condition			
Date of first symptom	DD/MM/YYYY	Beginning of treatment	DD/MM/YYYY	End of treatment	DD/MM/YYYY
Treatment (b) (c)					
Name of applicant					
Question No.		Illness or medical condition			
Date of first symptom	DD/MM/YYYY	Beginning of treatment	DD/MM/YYYY	End of treatment	DD/MM/YYYY
Treatment (b) (c)					
Name of applicant					
Question No.		Illness or medical condition			
Date of first symptom	DD/MM/YYYY	Beginning of treatment	DD/MM/YYYY	End of treatment	DD/MM/YYYY
Treatment (b) (c)					

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7 MEDICAL QUESTIONNAIRE (CONTINUED)

MEDICAL HISTORY

Medical exams: Has any of the applicants had a pediatric, gynecological or routine exam performed in the last 5 years? Yes☐ No☐ If your answer is "Yes", please explain.

Name		Type of exam		Date	DD/MM/YYYY

Results: Normal☐ Abnormal☐ If it is abnormal, please explain.

Habits: Has any applicant ever smoked cigarettes, consumed nicotine products, alcohol, or illegal drugs? Yes☐ No☐ If your answer is "Yes", please explain.

Name		Type		For how long?		Amount/day	

Family history: Does any applicant and/or dependent have a family history of diabetes, hypertension, cancer, or a congenital or hereditary cardiovascular disorder? Yes☐ No☐ If your answer is "Yes", please explain.

Applicant	Relative with condition				Condition
	Father	Mother	Sibling	Child	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

8 ATTENDING PHYSICIAN

If the applicant or any of the dependents have an attending physician, please write their information here:

Physician's name			
Specialty		Telephone	
Name of applicant			
Physician's name			
Specialty		Telephone	
Name of applicant			
Physician's name			
Specialty		Telephone	
Name of applicant			

9 SELECT YOUR PLAN AT

For details about the coverage of the selected plan, please consult the corresponding General Conditions and Table of Benefits.

Product	Deductibles					
	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6
	Inside/ouside Guatemala	Inside/ouside Guatemala	Inside/ouside Guatemala	Inside/ouside Guatemala	Inside/ouside Guatemala	Inside/ouside Guatemala
☐ Major Medical	US$5,000,000	☐ US$10,000/ US$10,000	☐ US$20,000/ US$20,000			
☐ Select	US$2,000,000	☐ US$250/ US$5,000	☐ US$2,000/ US$2,000	☐ US$5,000/ US$5,000	☐ US$10,000/ US$10,000	
☐ Premier	US$5,000,000	☐ US$250/ US$5,000	☐ US$2,000/ US$2,000	☐ US$5,000/ US$5,000	☐ US$10,000/ US$10,000	
☐ Elite	US$7,000,000	☐ US$250/ US$5,000	☐ US$2,000/ US$2,000	☐ US$3,500/ US$3,500	☐ US$5,000/ US$5,000	☐ US$10,000/ US$10,000
☐ Ultimate	Unlimited	☐ US$0/ US$0	☐ US$1,000/ US$1,000			

10 BENEFICIARY

AT

In case the insurance beneficiary is by any means unable to receive reimbursement of incurred medical expenses, the following person is designated as contingent beneficiary to receive payments on his/her behalf:

Names	FIRST NAME	MIDDLE NAME	OTHER NAMES
Last names	LAST NAME	MAIDEN NAME	MARRIED NAME
ID document No.		DPI ☐	Passport ☐
Relationship with beneficiary			

11 INFORMATION ABOUT OTHER INSURANCE COVERAGE

AT

If the applicant and/or dependent(s) currently have coverage for individual major medical expenses with another company and plan to keep it, please check this box ☐ and complete the following information:

Name of the company			
Policy number			
Renewal date	DD/MM/YYYY	Deductible amount	

12 CONSENT

AT

PRIVACY NOTICE

In accordance with the law, **BUPA GUATEMALA, COMPAÑÍA DE SEGUROS, S.A.** (hereinafter "the Insurer"), issues this Privacy Notice as follows:

The Insurer, located at 5ª Avenida 5-55, Zona 14, Europlaza World Business Center, Torre III, Nivel 11, Oficina 1103, Ciudad de Guatemala, informs you that it will use the personal information you provide with sensible data identification for the purposes indicated in this Privacy Notice.

The policyholder's and/or contracting party's personal data, including all sensible personal data, including medical data and information in medical records to which the Insurer may have access or that we may gather, unless the policyholder and/or contracting party indicates otherwise, is used to develop new products and services, advice, commercialize, promote, contract and place insurance products purchased by you or the company you represent, and for other obligations derived from any legal and commercial relationship between the policyholder and/or contracting party and the Insurer, to:

1. Evaluate and underwrite your insurance application, and if approved, issue an insurance contract; process claims reimbursements, facilitate policy management, maintenance, and renewal; prevent fraud and illicit operations; provide statistical information; evaluate service quality; inform you about your policy benefits; offer you available services through technological applications on your mobile devices ("apps") as well as for everything related to meeting our contractual obligations and complying with the law, and to share your information with agents as needed.
2. Inform you about new products and services, as well as benefits, discounts, promotions, market research, notifications about changes in conditions, and in general, all publicity derived from the services offered by the Insurer and/or its affiliates and subsidiaries.
3. Analyze the use of our products and services.
4. Comply with our terms and conditions as we offer our services.

The sensible data gathered may be used to identify contractual risk and to design insurance products.

As of this moment, by contracting the services offered by the Insurer, or by simply applying or requesting a quote for such services, it is understood that by signing this Privacy Notice you, as holder of your personal and sensible information, are expressly providing consent to share such information with:

1. Affiliates or subsidiaries and commercial associates of the Insurer worldwide.
2. Third party service providers, to comply with legal obligations acquired by the Insurer, its affiliates and subsidiaries, including providers of research services, data analysis, information delivery focused on the needs of the holder of personal information, and to provide other financial services needed or required by the holder of personal information. The third parties and other recipients of personal information are bound by the same obligations and responsibilities as the Insurer, as described in this Privacy Notice.
3. National or foreign financial authorities, in order to comply with our obligations derived from the law and international treaties as an insurance company, tax obligations, and notifications and official requirements.
4. National or foreign judicial authorities, in order to comply with the law, notifications, requirements, or judicial documentation.
5. Insurance institutions, organizations, or entities, in order to prevent fraud and risk selection.

In order to exercise your right to access and revocation, please send written request to 5ª Avenida 5-55, Zona 14, Europlaza World Business Center, Torre III, Nivel 11, Oficina 1103, Ciudad de Guatemala, or by e-mail at privacidad@bupalatinamerica.com; whichever method you choose, the person responsible for your personal information will contact you. All the information gathered here will be treated according to the law, or any law that replaces, subrogates, or modifies it. The confidentiality of this information is guaranteed and protected in order to avoid its improper use or disclosure.

I have read and understood this Privacy Notice and agree with all its terms.

CONSENT AND STATEMENTS

I hereby certify that the information and data in this application is truthful and complete.

I am the legal representative of the people cited in this application form, or I have obtained prior consent to submit this application from them, to give consent and to make statements on their behalf.

I agree to be bound by the terms of my health plan policy (and for the coverage to any other person under this policy).

I give my consent to the Insurer, on my behalf and on behalf of any other person covered by this policy, to process all the personal data according to the Privacy Notice previously stated. I confirm to have disclosed this Privacy Notice to all the persons mentioned above.

I understand that the benefits may not be paid in their entirety or at all, and that my policy may be terminated if I do not provide the information requested in this application. Wherever I have provided information on behalf of another person covered by this policy, I confirm to have discussed with them the accuracy of the information before the completion of this application. I agree that the applicable laws in the Republic of Guatemala will be applied to this policy.

NOTICES AND CONDITIONS

In consideration of the previous statements, it is essential that you provide us with all the information requested. We are unable to process your application if this document is incomplete. Please review it before submitting it.

If you do not take the necessary precautions to provide us with the complete and accurate information, we have the right to treat your policy as it had never existed, or we may reject the payment of a claim in its entirety or in part.

If you do not take the necessary precautions to provide complete and accurate information regarding any of the persons covered by this policy, it may affect the coverage of those persons.

We recommend you to keep a copy of all the information you have provided us regarding this application, including any document or form.

If you would like to receive a copy of this application, please request from the Insurer. This form must be received by the Insurer within six weeks following the signing of this document.

It is understood and agreed that Bupa Guatemala, Compañía de Seguros, S. A. reserves the right to reject or accept any insurance application.

The answers and statements included in this application are complete, truthful, and to the best of my knowledge. Any omission, inaccuracy or false statement in the application may allow the Insurer to terminate the insurance contract.

ACKNOWLEDGMENT AND AUTHORIZATION

I understand that any coverage I may acquire in the United States of America or any other country may lead to the termination of my coverage with Bupa Guatemala, Compañía de Seguros, S.A. Also, I must inform Bupa Guatemala, Compañía de Seguros, S. A. if I or any of my dependents under this policy, become permanent residents of the United States of America or any country other than Guatemala.

I have reviewed and understand the content and purpose of this Acknowledgment and Authorization. With my signature and affirmative answers, I confirm that all the authorizations regarding my decisions herein reflect my wishes. My signature here represents the approval of all statements herein. This application is effective for 90 calendar days from the date it has been signed.

If any of the insureds requires health care or medical treatment after this insurance application has been signed, but before the effective date of the policy, the policyholder must provide Bupa Guatemala, Compañía de Seguros, S.A. complete details for its final approval before coverage is in effect. In case the policy is approved during this period, Bupa Guatemala, Compañía de Seguros, S.A. reserves the right to modify the conditions of approval of the policy and/or its effective date.

Policyholder's signature		Date	DD/MM/YYYY
Policyholder's name			
Contracting party's signature		Date	DD/MM/YYYY
Contracting party's name			

PROCEDURE TO FILE A CLAIM

If you have any concerns or complaints, please contact a customer service representative at PBX 2300-8000. You may also contact us by e-mail at: ServicioGuatemala@bupalatinamerica.com, or visit our office at:

5ª Avenida 5-55, Zona 14
Europlaza World Business Center
Torre III, Nivel 11, Oficina 1103
Ciudad de Guatemala

13 ACKNOWLEDGEMENT AND CONSENT (TO BE COMPLETED BY THE BROKER/AGENT)

Insurance brokers must inform their clients clearly and in detail regarding the scope of the coverage they are purchasing, and how to renew or cancel their policy. Likewise they will provide the Insurer with all the accurate information related to the risk for the proposed coverage so the Insurer may make an assessment and establish adequate conditions and premiums in accordance with applicable regulations.

While carrying out their duties, they must adhere to the information provided by the Insurer, as well as its premiums, policies, amendments, insurance plans and other technical information used by the Insurer.

The broker/agent hereby states that he/she has explained to the insured the scope and general conditions of this Insurance policy and that he/she does not know of any condition that has not been disclosed in this application that may affect insurability of the proposed insured(s).

I am unaware of any conditions not disclosed in this application that may affect the insurability of the applicants.

Broker's code		Name	
Date	DD/MM/YYYY	Signature	

14 PAYMENT DETAILS AT

FREQUENCY OF PAYMENT: ☐ ANNUAL ☐ SEMI-ANNUAL ☐ OTHER:	
PREMIUM AMOUNT (US$)	

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14 PAYMENT DETAILS (CONTINUED) AT

PAYMENT METHOD: OPTION 1

☐ CASHIER'S CHECK ☐ PERSONAL CHECK

DO NOT SEND CASH. Checks must be issued to Bupa Guatemala, Compañía de Seguros, S.A.

PAYMENT METHOD: OPTION 2

☐ BANK TRANSFER

111 Wall Street, New York, NY 10043
Account number: 36073519
ABA # 021000089
SWIFT # CITIUS33
CHIPS # 008
Telex & Routing Code: NYCRB
IBAN # GT22CITI02010000000700501019

BENEFICIARY BANK:
CITIBANK, N.A.
Sucursal Guatemala
To be credited to:
Bupa Guatemala, Compañía de Seguros, S.A.
Account number: 0-700501019

PAYMENT METHOD: OPTION 3

☐ CREDIT CARD

I, _____ the cardholder, hereby authorize Bupa Guatemala, Compañía de Seguros, S.A. using the bank institution of its choosing, and based on the credit or debit contract supporting my Visa, Master Card, American Express, or Diners card, to charge the initial, subsequent, and renewal premiums agreed in the policy. Such charge will be made in U.S. Dollars. I agree to have an adequate account balance to cover such payments based on the policy's effective date, selected payment method and frequency of payment. If charges are not registered in the bank statement, it is my obligation to notify Bupa Guatemala, Compañía de Seguros, S.A.

I hereby acknowledge and agree that Bupa Guatemala, Compañía de Seguros, S.A. will stop providing the contracted services described in the policy contract once grace period is over, due to:

1. Cancellation or changes in the banking instrument not notified to Bupa Guatemala, Compañía de Seguros, S.A.
2. Bank rejection.
3. Cancellation of the policy for lack of payment.

CARD:	MasterCard ☐	VISA ☐	AMERICAN EXPRESS ☐	DINERS CLUB INTERNATIONAL ☐

Credit card number		Expiration date	MM/YYYY
Amount to debit (US$)		Installments: Yes ☐ No ☐	
Amount of installments: 3 ☐ 6 ☐ 10 ☐ 12 ☐		Issuing bank	
Security code		Telephone number	E-mail
Cardholder's address			

By signing below I authorize Bupa Guatemala, Compañía de Seguros, S.A. to charge my credit and/or debit and/or bank account indicated above to pay for my policy's insurance premiums. I understand that if there are any changes to my Bupa policy, the premium may also change. I also understand that a copy of this document will be sent to my banking institution or credit card company. By signing here, I request and authorize the corresponding institution to allow the insurer to charge my credit and/or debit and/or bank account directly to pay for my insurance premium, unless I notify otherwise.

By signing, I also authorize automatic deductions for future renewals.

Cardholder's signature		Date	DD/MM/YYYY

INVOICING INFORMATION

Name		NIT	
Address			

Relationship with the Policyholder: ☐ Self ☐ Spouse ☐ Parent

☐ Child ☐ Sibling ☐ Grandchild ☐ Grandparent ☐ Legal guardian

☐ Other: _____

This form meets all the requirements established in the IVE-ASR-32

This content is the insurer's responsibility, and it has been registered at the Superintendence of Banks, according Resolution Number 354-2018 dated February 14, 2018, which does not prejudge the content in this document itself.

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