EXTRAORDINARY BENEFITS REQUEST FORM

Bupa

Completed by	Last Name	Name	Middle Initial

Date	MM / DD/ YY	Date received by the team	MM / DD/ YY	Case number	

Insured's name			
Policy number		Country of residence	
Annual deductible		Deductible met	
Product		Producer code	
Requested by		☐ Insured ☐ Agent	
General producer's name		Code	
Claim number (if applicable)			
Last 5 years premium		Policy claims paid (all)	
Effective date/Commencement date of policy	MM / DD/ YY		

Requested amount: US$	

Reason for Denial (please check all that apply)

☐ UCR ☐ Filing limit ☐ General policy exclusion ☐ Individual policy exclusion

☐ Policy condition ☐ Out of network

☐ Other:

Other relevant information/comments:

Review date	MM / DD/ YY	Signature	
Decision			

SUMBIT

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