

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
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