Grupo Nacional Provincial, S.A.B.
Av. Cerro de las Torres 395, Colonia Campestre Churubusco
c.p. 04200, México D.F.

Medical report

The treating doctor must complete this form in block capitals and sign it. Please do not leave any questions unanswered or blank spaces.
This form will not be valid if it contains any deletion or alteration and may not be changed at a later date.

Description		
☐Arranging surgery	☐Arranging medical treatment	☐ Refund

Patient details			
Patient's name			Start date
Paternal surname	Maternal surname	Name (s)	Day month year
Sex	Age	Policy No.	Reason for treatment
☐ M ☐ F			☐Pregnancy ☐Illness ☐ Accident

Medical record (specify time of development)	
Personal pathology record	Personal non-pathological record
Gynecological-obstetric record	Perinatal record (if necessary)

Current condition	
Please state when the condition first appeared, according to medical records and the natural development of the illness	Start date Day month year

ICD code	Final diagnosis (es)	Start date Day month year

Type of condition	
☐ Congenital ☐ Acquired ☐ Acute ☐ Chronic	Have you been related to any other condition? ☐Yes ☐ No Which?
Result of physical examination and studies carried out (attach interpretations that confirm diagnosis)	

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Treatment		
CPT4. Reference only	Descriptionof treatment	Start date Day month year

ICD code	Description of complications	Start date Day month year
☐Yes ☐ No		

Additional information

Hospital	**City**	**State**

Type of stay	Start date Day month year
☐Emergency ☐ Hospital ☐Short stay/outpatient	

Details of doctors involved in treatment or consulting physician (s)				
Paternal surname	Maternal surname	Name (s)		Nature of involvement
Specialty	Professional license	Specialty license or certification		Quotation
Telephone No.	Cell No.	Fax No.	Pager	E-mail address
Paternal surname	Maternal surname	Name (s)		Nature of involvement
Specialty	Professional license	Specialty license or certification		Quotation
Paternal surname	Maternal surname	Name (s)		Nature of involvement
Specialty	Professional license	Specialty license or certification		Quotation

The above information is provided based on the medical examination that I carried out on the patient, the information I have available, the medical studies that I have carried out at my own responsibility, and on the references provided by the patient and or his/her relations.

Place and date

Name and date of treating doctor

Grupo Nacional Provincial, S.A.B.
Av. Cerro de las Torres 395, Colonia Campestre Churubusco
c.p. 04200, México .D.F.

Medical Expenses

Notice of accident or illness
(Refund, arranging for services and/or medical treatment)

This form must be completed accurately, in detail and be signed by the Insured.
Submitting this form does not mean that the Company is required to admit that the claim is valid nor that it waives the rights it reserves under the policy.
This form will be invalid if it contains any deletion ad/or alteration.

Policy No.	Date
	Day month year

I. Details of main Insured Party

Paternal surname | Maternal surname | Names (s) | Customer code or certificate No.

Tax No. letters | Year | month | day | code | Unique citizen's number | Sex ☐F ☐M | Nationality (if not Mexican)

Marital status ☐ S ☐M ☐ D ☐W ☐CL | Current occupation | Job or line of business

Does the Insured hold or has the Insured held a position in state or federal government in the last four years? ☐ Si ☐ No | State position | E-mail address

Private address

Street | No. | No. interior

Precinct | Zip code

Municipality or district | City or town | State | Country | Code | Tel. No

II.Details of Insured affected (if not the main Insured Party)

Paternal surname | Maternal surname | Name (s) | Customer code or certificate No.

Tax No. letters | year | month | day | code) | Occupation | Relationship with Main Insured Party | Sex ☐F ☐M | Marital status ☐ S ☐ C ☐ D

Address(if different to that of Main Insured Party)

Street | No. | Apt./suite

Precinct | Zip code.

Municipality or district | City or town | State | Country | L.D. code | number

Place at which attention given

State | Municipality or district

III. Details of contracting party (individual) (if not the Main Insured Party)

Paternal surname | Maternal surname | Name (s) | Customer code

Tax No. letters | year | month | day | code | Unique citizen's number | Sex ☐F ☐M | Nationality (if not Mexican)

Current occupation | Line of business or profession | E-mail address

Does the contracting party or has the contracting party held a position in state or federal government in the last four years? ☐Yes ☐ No | State position | Relationship with main Insured Party

Contracting party (if corporate entity moral)

Corporate name | Customer code

Tax No. letters | year | month | day | code | Line of business or corporate purpose | E-mail address or web site

Name of legal representative

Paternal surname | Maternal surname | Name (s)

Name of contracting party (individual or corporate entity)

Street | No. | Apt./suite

Precinct | Zip code.

Municipality or district | City or town | State | Country (if not Mexico) | L.D. code | number

If you require further information, please call us on 5227 9000 in Mexico City, or 01 800 400 9000 long distance toll free, from any other part of the country, or visit gnp.com.mx

Have you claimed expenses for this condition from us or another company? Type of claim ☐First ☐ Complementary	Claim No.
Type of condition: ☐ Accident ☐Illness ☐Pregnancy	State the diagnosis that backs your claim
Type of hospitalization	Date of accident or date on which condition appeared day mont h year

If a traffic accident: was the vehicle (s) insured?	☐Yes☐ No	Name of company	Coverage	Insured sum (GM)	Policy No.

Attach copy of police report or report of the Company, plus an interpretation of studies carried out

Hospital	Date of scheduled admission	time day month year

Name of doctor	Specialty	Does he/she have an agreement with the Company? ☐Yes☐ No

Who referred you to the doctor?

☐ GNP Seguros ☐ Hospital ☐ Other

I hereby declare that all information provided is true and accurate and is based on the medical records of which I am aware, the consequences of which I will be responsible for.

Catastrophic illness coverage Nacional (CEC-Nacional) for Premier 300 policies

If you have taken out this coverage, state if you wish to arrange for medical attention: ☐Yes☐ No

IMPORTANT:
The conditions covered by CEC-Nacional are: cancer, neurological and cerebral-vascular diseases, coronary diseases that require surgery, heart, liver, kidney bone marrow and lung transplants.
If coverage:

- IS ACCEPTED: GNP will allocate you a Hospital and a treating doctor, which may not be those that you specify on this form.
- IS REJECTED. The claim will be handled under basic coverage conditions with the Hospital and treating doctor that you specify on this form.

Personal details and consent:
I have read the Privacy Notice of Grupo Nacional Provincial, S.A.B. that contains and states the purpose of the handling of my personal data, treatment, property data and sensitive data. I have also been informed of the availability of the Privacy Notice and any changes made to it, on the web site www.gnp.com.mx. Therefore:

☐**Yes, I consent to my data being handled** ☐**No, I do not consent to my data being handled**

If the personal data of other owners of data have been provided, I acknowledge that I am required to notify said persons accordingly and of where the Privacy Notice may be consulted.

Name and signature of the Insured and/or Contracting Party

Name of broker	Code	Telephone number	State

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Grupo Nacional Provincial, S.A.B.
Av. Cerro de las Torres 395, Colonia Campestre Churubusco
c.p. 04200, México .D.F.

For GNP use only

Refund of accident and/or illness

Please submit this form together with original receipts.
This form will be invalid if it has any deletion and/or alteration.

Policy No..	Date
	day month year

I. Details of Main Insured Party

Paternal surname	Maternal surname	Name (s)	Customer code or certificate No.

II. Details of affected Insured Party

Paternal surname	Maternal surname	Name (s)	Customer code or certificate No.

Relationship with Main Insured Party	Condition	First payment?
		☐Yes ☐ No

If payment is additional payment, note the number of the first claim made for this treatment	Claim No. if direct payment requested

III. Details of contracting party (if not the Main Insured Party)

Name or corporate name	Customer code

IV. Details of refund

Línea Azul Certeza

If you are not insured under this scheme, please continue to the Breakdown of Refund section.

If you are insured under this scheme, state the coverage of your choice. If not, or if you choice is not acceptable, all forms of coverage acceptable will be processed:

☐Serious Illnesses
(if you choose this option, please complete the "Breakdown of Refund" section")

☐Surgery

☐Hospitalization

IMPORTANT:
You may consult details of the illnesses and surgery covered hereby in your general conditions that you will find on our web site at**gnp.com.mx** or you may call Línea GNP on 5227 9000 (from Mexico City) or 01 800 400 9000 toll free (from the rest of the country.

State date of disability only if you have daily indemnity for accident and illness. day month year

Breakdown of refund

Description	Amount of expenses
1. Expenses outside hospital (Drugs, analyses, X-rays, studies, etc.)	
2. Medical fees for consultations	
3. Hospitalization expenses	
4. Medical fees for surgery (fee of surgeon, assistant and anesthetist)	
5. Other expenses (specify)	
Note: Total expenses claimed must coincide exactly with the total shown on receipts, preferably submitted in the order shown above. Total	

V. Place where you were treated

Municipality or district	Town and/or state

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VI. Instructions for payment by wire transfer

State name and tax number of the person to whom payment is to be made.

☐Main Insured Party /Participant	☐Affected Insured Party /Participant (only if of majority age)	☐Father, mother or tutor(only f the Insured /Participant is of minority age)

Paternal surname	Maternal surname	Name (s)	Tax No. letters	year	month	day	code)

E-mail address for notice of payment (Insured)	E-mail address for notice of payment (Agent/Risk Manager)

* For Contracts in which the Affected Insured Party/Participant is of minority age, please state relationship. Also please attach the customer identification form, a copy of his/her official ID, a copy of his/her proof of address and all supporting documents that prove the identity of the father, mother or tutor of the minor.	Relationship with Insured/Participant ☐Father ☐ Mother ☐ Tutor

1. If you are requesting a refund of major medical expenses from GNP for the first time, please submit the **bank details for wire transfer form** duly completed.
2. If you are not requesting a refund of major medical expenses from GNP for the first timeand you have a payment account registered with GNP, state the last four digits..

☐Inter-bank T/F code___ ___ ___ ___

☐Debit card ___ ___ ___ ___

☐ GNP electronic wallet ___ ___ ___ ___

NOTE: If you do not provide the information asked for, payment will be made to the account to which the last refund was paid.

3. If payment is rejected by your bank, please notify:

Broker Telephone number: _____

Payment beneficiary Telephone number: _____

Personal details and consent:
I have read the Privacy Notice of Grupo Nacional Provincial, S.A.B. that contains and states the purpose of the handling of my personal data, treatment, property data and sensitive data. I have also been informed of the availability of the Privacy Notice and any changes made to it, on the web site www.gnp.com.mx. Therefore:

□ **Yes, I consent to my data being handled** □ **No, I do not consent to my data being handled**

If the personal data of other owners of data have been provided, I acknowledge that I am required to notify said persons accordingly and of where the Privacy Notice may be consulted.

_____

Signature of the Insured

Instructions for making claims by refund in the event of accident and/or illness

Important note: we recommend that you read the conditions of your contract before submitting your claim, as there are certain exclusions and restrictions. If you have any doubts, please contact your broker.

To be able to process and pay your claim more quickly and efficiently, please make sure that you meet the following requirements:

1. a) Accident and/or illness refund claim form.
   b) Notice of accident or illness and medical report.
   c) Expense receipts that meet tax requirements.
   d) Copy of complete medical record.
   e) Interpretation of studies and copy of studies carried out
2. The doctor who attended you must complete the medical report, paying particular attention to the diagnosis given and the dates requested.
3. Original receipts must be submitted for checking (hospital invoice, receipts from doctors, assistants, drugstore invoices with prescription, etc.). Receipts for fees must be signed by the person who issued them.
4. Receipts for the fees of doctors, assistants and anesthetists must be raised on the forms established by the Treasury Departmentin the name of the Main Insured Party. Receipts must specify description, e.g. consultation, medical assistance, etc. Receipts for expenses must be raised in the name of the Main Insured Party.

6. a) Accident and/or illness refund claim form.
   b) Notice of accident or illness and medical report.
   c) Expense receipts that meet tax requirements.
   d) Copy of complete medical record.
   e) Interpretation of studies and copy of studies carried out
5. The doctor who attended you must complete the medical report, paying particular attention to the diagnosis given and the dates requested.
6. Original receipts must be submitted for checking (hospital invoice, receipts from doctors, assistants, drugstore invoices with prescription, etc.). Receipts for fees must be signed by the person who issued them.
7. Receipts for the fees of doctors, assistants and anesthetists must be raised on the forms established by the Treasury Departmentin the name of the Main Insured Party. Receipts must specify description, e.g. consultation, medical assistance, etc. Receipts for expenses must be raised in the name of the Main Insured Party.

Remember:

Arranging your surgery or medical treatment in advance provides you major benefits

Make the most of them!

40 20 23

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Bank Details Form for Payment by Wire Transfer

Affiliation code (for GNP use only)

Tick the option you require (you may tick both if you wish)

☐Registering account (complete sections I and II) ☐Cancellation of account (complete sections I and II)

I. General Information

Name or corporate name of holder of bank account (as shown on bank statement)

Tax address of account holder

Street	No.	Apt./Suite	Precinct	Zip code

Municipality or district	City or town	State	Telephone No. (home/office) L.D. code	Ext.

Telephone No. (cell)	Tax No. of account holder	letters	year	month	day	Code	Unique citizen's number

II. Registering bank accounts

Choose one of the following payment options and provide the information asked for:

Option

A ☐Inter-bank T/F code

Make payments by wire transfer using the 18-digit inter-bank transfer code shown on the statement or that may be provided by any branch of your bank

__ __ __ – __ __ __ – __ __ __ __ __ __ __ __ __ __ – __

B ☐Card number

Pay by debit card specifying the 16-digit number and the bank

__ __ __ __ – __ __ __ __ – __ __ __ __ – __ __ __ __

Bank:_____

C ☐ GNP electronic wallet

Make payment by the GNP electronic wallet..
I hereby confirm that the account number will be provided by Grupo Nacional Provincial, S.A.B.
When the GNP electronic wallet is opened in the name of a minor, responsibility for the use and handling of the card shall be that of the legal representative, and Grupo Nacional Provincial, S.A.B. shall not be liable for any claim made in this regard.

For GNP use only
Number of GNP electronic wallet:

__ __ __ __ – __ __ __ __ – __ __ __ __ – __ __ __ __

Providing the GNP electronic wallet does not guarantee the payment requested.

III. Cancellation of bank accounts

Specify type of account and the last four digits of the account number to be cancelled:

☐Inter-bank T/F code ☐☐☐☐ ☐Debit card No.☐☐☐☐ ☐ GNP electronic wallet ☐☐☐☐

I hereby request and authorize Grupo Nacional Provincial, S.A.B., to make any payment to which I am entitled under the insurance contract signed with it, in the manner specified above.

When the amount payable in accordance with the policy has been paid made in the manner specified, I confirm that said payment has been made and grant Grupo Nacional Provincial, S.A.B. the broadest possible release allowed by law.

Grupo Nacional Provincial, S.A.B. (GNP) will handle personal data as established in its Privacy Notice that may be consulted on its web site at www.gnp.com.mx in the Privacy Notice section.

Name and signature of account holder or legal representative of the company

Please attach the documents below

Individuals

- Copy of upper section of bank statement that shows name of account holder and account number, or a formal document issued by the bank that states who the account holder is and the account number.
- Copy of official identity card.

Companies

- Copy of upper section of bank statement that shows name of account holder and account number, or a formal document issued by the bank that states who the account holder is and the account number.
- Copy of articles of incorporation
- Copy of company tax card
- Copy of official identity card of legal representative.
  If representation is formalized on a document other than the articles of incorporation, attach a copy of the power of attorney of the legal representative.

IV. For Grupo Nacional Provincial, S.A.B. use only

☐Account registered ☐Information checked against documents attached
☐Account cancelled ☐Bank account not found

Received stamp