GLOBAL HEALTH PLANS

INSURANCE APPLICATION FOR INDIVIDUAL MAJOR MEDICAL EXPENSES

BUPA DOMINICANA

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.

Policyholder: The person for whom the policy is issued, and who is authorized to receive reimbursement of medical expenses and refunds of any unearned premium.

Contracting party: The person who signes this application and is bound to pay the premium. He/she may or may not be the Policyholder.

IMPORTANT INFORMATION

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

Once completed, please scan and send your form to: bupadominicana@bupalatinamerica.com. In order for the policy to be issued, the signed original and your identification documentation must be received in our offices at Av. Winston Churchill, No. 1099, Acrópolis Center, 3er Nivel Piantini, Santo Domingo, República Dominicana.

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 Dominicana, S.A.

FOR **NEW INSUREDS**

Please complete sections 2 to 10 and section 13.
Read, sign and date the Consent in section 11.
The insurance broker must fill out and sign section 12.

FOR **CURRENT INSUREDS**

You may request changes to this plan by completing this form. Please read, sign and date the Consent in section 11.

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

- Complete sections 1 to 3, if applicable.
- Complete section 9, if applicable.
- Read, sign and date the Consent in section 11.

Adding a new person to your plan:
- Complete sections 1, and 5 to 7.
- Complete sections 9 and 10, if applicable.
- Read, sign and date the Consent in section 11.

Changing coverage (only within Global Health Plans):
- Complete sections 1, and 6 to 8.
- Read, sign and date the Consent in section 11.

Changing your payment method:
- Complete sections 1 and 13.
- Read, sign and date the Consent in section 11.

Bupa Dominicana, 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

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 POLICYHOLDER: DETAILS OF CURRENT POLICY

AT

Policy number	

2 CONTRACTING PARTY INFORMATION

INDIVIDUAL: PERSONAL INFORMATION

Coverage begins on the effective date specified on your Certificate of Coverage, if approved.

Marital status: Single ☐ Married ☐	Male ☐ Female ☐	Weight in Lbs.		Height in feet	
Names					
Last names					
Nationality		Country of residence			
ID type		Number			
Date of birth	DD/MM/YYYY	Country of birth			
Commercial activity					

Is the applicant a Politically Exposed Person (PEP)? Yes ☐ No ☐

Is the applicant a relative of a PEP? Yes ☐ No ☐ | Is the applicant an associate of a PEP? Yes ☐ No ☐

LEGAL ENTITY

Name of business			
Mercantile registration: Date	DD/MM/YYYY	Number	
RNC			
Main activity			
Annual income/revenue			
Legal representative			
Type of Identification		Number	

CONTACT INFORMATION

Address					
Years at this address		Postal code		City	
Province		Country		Telephone number(s)	
E-mail		Cellphone number			
Place of work: Name		Telephone number(s)			

3 POLICYHOLDER INFORMATION

AT

PERSONAL INFORMATION

Marital status: Single ☐ Married ☐	Male ☐ Female ☐	Weight in Lbs.		Height in feet	
Name					
Last names					
Date of birth	DD/MM/YYYY	Country of birth			
Nationality		Commercial activity			
ID type		Number			

Is the applicant a Politically Exposed Person (PEP)? Yes ☐ No ☐

Is the applicant a relative of a PEP? Yes ☐ No ☐ | Is the applicant an associate of a PEP? Yes ☐ No ☐

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

POLICYHOLDER'S CONTACT INFORMATION

Complete only if different from Contracting party.

Address					
Years at this address		Postal code		City	
Province		Country		Telephone number(s)	
E-mail		Cellphone number			
Place of work: Name		Telephone number(s)			

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:

4 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. ☐

5 ADDITIONAL POLICY MEMBERS

1

Names			
Last names			
Marital status: Single ☐ Married ☐	Male ☐ Female ☐	Weight in Lbs.	Height in feet
Nationality		Country of residence	
ID type		Number	
Date of birth	DD/MM/YYYY	Occupation or profession	
Relationship with the Policyholder		E-mail	

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 ☐

2

Names			
Last names			
Marital status: Single ☐ Married ☐	Male ☐ Female ☐	Weight in Lbs.	Height in feet
Nationality		Country of residence	
ID type		Number	
Date of birth	DD/MM/YYYY	Occupation or profession	
Relationship with the Policyholder		E-mail	

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 ☐

3

Names			
Last names			
Marital status: Single ☐ Married ☐	Male ☐ Female ☐	Weight in Lbs.	Height in feet
Nationality		Country of residence	
ID type		Number	
Date of birth	DD/MM/YYYY	Occupation or profession	
Relationship with the Policyholder		E-mail	

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 ☐

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

5 ADDITIONAL POLICY MEMBERS (CONTINUED)

4

Names								
Last names								
Marital status*		Male ☐ Female ☐	Weight		Kg ☐ Lbs ☐	Height		Mts.
Nationality			Country of residence					
ID type			Number and extension					
Date of birth	DD/MM/YYYY		Occupation or profession					
Relationship with the Policyholder			E-mail					

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.

6 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)	
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, tumors 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)	

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

6 MEDICAL QUESTIONNAIRE (CONTINUED)

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)	
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)	

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

6 MEDICAL QUESTIONNAIRE (CONTINUED)

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)					

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	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

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

7 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			

8 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
	Inside/outside Dominican Republic	Inside/outside Dominican Republic	Inside/outside Dominican Republic	Inside/outside Dominican Republic	Inside/outside Dominican Republic
☐ Major Medical	☐ US$7,500/ US$7,500	☐ US$10,000/ US$10,000	☐ US$20,000/ US$20,000	-	-
☐ Select	☐ 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$250/ US$5,000	☐ US$2,000/ US$2,000	☐ US$5,000/ US$5,000	☐ US$10,000/ US$10,000	-
☐ Elite	☐ 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	☐ US$0/ US$0	☐ US$1,000/ US$1,000	-	-	-

9 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:

Last name			
Maiden name			
Names			
ID type		Number	
Phone number		E-mail	

10 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	

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

PRIVACY NOTICE

In accordance with the Federal Law for the Protection of Personal Data Held by Individuals, BUPA DOMINICANA, S.A. (hereinafter “the Insurer”), issues this Privacy Notice as follows:

The Insurer, located at Av. Winston Churchill, No. 1099, Acrópolis Center, 3er Nivel Piantini, Santo Domingo, República Dominicana, 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 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, in accordance with the Law on Insurance Contracts and its rules, 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 revoke the consent, you must send written communication to the address specified in this Privacy Notice, or by email to privacidad@bupalatinamerica.com.

Any changes to this Privacy Notice will be informed in the Insurer’s internet portal, www.bupasalud.com, or by any communication means we have with you. We do recommend you to frequently visit our above mentioned website.

All the information collected by this means will be treated in accordance with the Personal Data Protection law. The confidentiality of this data is guaranteed and protected to avoid its misuse and improper disclosure.

I have read and acknowledge this Privacy Notice; I also agree with all its terms.

CONSENT TO SHARE YOUR MEDICAL INFORMATION

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 disclose 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 Dominican Republic will be applied to this policy.

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

11 CONSENT TO SHARE YOUR MEDICAL INFORMATION (CONTINUED) AT

NOTICES AND CONDITIONS

In consideration of the previous statements, it is essential that you provide us with all the information requested. We will be 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 after it is signed and dated. Otherwise, we will not be able to process your application, and you will need to fill out and submit a new form.

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 Dominicana, S.A. Also, I must inform Bupa Dominicana, 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 the Dominican Republic.

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 Dominicana, S.A. complete details for its final approval before coverage is in effect. In case the policy is approved during this period, Bupa Dominicana, 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 (809) 955 2555. You may also contact us by e-mail at: bupadominicana@bupalatinamerica.com, or visit our office at:

Av. Winston Churchill, No. 1099,
Acrópolis Center, 3er Nivel Piantini,
Santo Domingo, República Dominicana

12 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 regulation. 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 insurance institutions.

Insurance brokers, intermediaries or consultants may not intervene in the purchase of an insurance policy as determined by the corresponding regulation, when their intervention may imply situations of coercion or failure to adhere to generally accepted professional practices.

Insurance brokers, intermediaries or consultants may not provide false information to the insurance institutions, nor information that is detrimental or adverse in any way for them.

As brokers, intermediaries or consultants, I accept complete responsibility to submit this application, the delivery of all the premiums charged, and the delivery of the policy once it is issued. Likewise, I certify that I have explained to the policyholder the scope and general conditions of this insurance policy.

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

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

13 PAYMENT DETAILS AT

FREQUENCY OF PAYMENT: ANNUAL ☐ SEMI-ANNUAL ☐ QUARTERLY ☐ MONTHLY ☐

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

13 PAYMENT DETAILS (CONTINUED)

AT

PAYMENT METHOD: OPTION 1	PAYMENT METHOD: OPTION 2
☐ CASHIER'S CHECK ☐ PERSONAL CHECK ☐ MONEY ORDER ☐ BANK DEPOSIT **FOR ACCOUNT DEPOSIT:** Banco Popular Dominicano, S.A Account in U.S. dollars No. 745108159 Account in Dominican Pesos No. 717827885 **DO NOT SEND CASH.** Checks must be issued to Bupa Dominicana, S.A.	☐ BANK TRANSFER **INTERMEDIARY BANK:** Citibank N.A. 111 Wall Street New York, NY 10043 SWIFT: BPDODOSX ABA: 021000089 **BENEFICIARY BANK:** Banco Popular Dominicano República Dominicana To be credited to: Bupa Dominicana, S.A. Account No. 745108159

PAYMENT METHOD: OPTION 3

☐ CREDIT CARD

I, ______________________________ the cardholder, hereby authorize Bupa Dominicana, S.A., using the bank institution of its choosing, and based on the credit or debit contract supporting my Visa, Master Card or American Express 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 Dominicana, S.A.

I hereby acknowledge and agree that Bupa Dominicana, 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 Dominicana, S.A.
2. Bank rejection.
3. Cancellation of the policy for lack of payment.

CARD: ☐ ☐ ☐

Credit card number		Expiration date	MM/YYYY
E-mail		Security code	
Cardholder's address			

If the policy conditions provide future premium modifications (renewals, additions, etc.), I agree that the charges to my account reflect the modified premium, prior notification of the premium increase by Bupa Dominicana, S.A. In order to avoid the cancellation of the policy, all charges may be processed up to two days prior to the initial date of each payment period.

I understand that only the contracting party has the right to choose a different payment method or to cancel the authorization of automatic payments whenever he/she deems necessary, prior notification in writing to Bupa Dominicana, S.A. 15 days before the date of each payment period.

I agree that if credit card payment of my insurance premium is rejected, it is my responsibility to pay such premium within 30 days of the effective date of the policy. Otherwise, my policy will be cancelled according to the law.

Cardholder's signature		Date	DD/MM/YYYY

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

13 PAYMENT DETAILS (CONTINUED) AT

INFORMATION ABOUT THE PAYER (IF DIFFERENT FROM POLICYHOLDER): PERSONAL INFORMATION

Marital status: Single ☐ Married ☐ Sex: Male ☐ Female ☐

Names			
Last names			
Nationality		Country of residence	
ID type		Number	
Date of birth	DD/MM/YYYY	Occupation or profession	
Financial activity		Place of work	
Work address			
Phone number		E-mail	
Politically Exposed Person (PEP)	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 ☐	

PAYMENT DETAILS

Policyholder					
Relationship with the Policyholder					
☐	Self	☐	Parent	☐	Sibling
☐	Grandchild	☐	Spouse	☐	Child
☐	Grandparent	☐	Legal guardian	☐	Other:

It is the agent's responsibility to verify the card information, being responsible for it. We request photocopy of both sides of the cardholder's identification card.

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

RESTRICTED-CONFIDENTIAL WHEN COMPLETED

This page intentionally left blank

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

Bupa Dominicana, S.A.
Av. Winston Churchill, No. 1099
Acrópolis Center, 3er. Nivel, Piantini
Santo Domingo, República Dominicana
Ph: (809) 955 2555
www.bupasalud.com

DOM-SSEG-GHP-ENG-V21.01