Accident or Illness Notice

Instructions:

1. This form must be completed in block letters and signed by the policyholder and the affected insured.
2. It must be completed in full and complete, detailed information must be provided.
3. It will not be valid if it contains erasures or alterations.
4. Providing the information requested below does not constitute a commitment by Prevem Seguros S.A. de C.V. to admit the validity of the claim, nor does it constitute a waiver of any rights reserved under the contract. No subsequent changes to the information declared by the insured will be accepted.

A. General Information - Affected Insured Information.

Policyholder's Last Name, Maternal Last Name, and First Name:

_____

Affected Insured's Last Name, Maternal Last Name, and First Name:

_____

Date of Birth: _____ dd/mm/yyyy _____ Sex: ☐ M ☐ F

Relationship to Policyholder: _____ Contact Telephone: _____

Nationality: _____ Email: _____

Street: _____ Exterior N° _____ Interior N° _____

Neighborhood: _____ ZIP Code: _____

Municipality/County: _____ City State _____

POLICY: _____

B. Reason for Claim.

☐ Reimbursement	☐ Direct Payment	☐ Surgery-Treatment Scheduling
☐ Accident	☐ Illness	☐ Pregnancy

C. Questions Related to the Illness or Accident Being Reported.

Date the accident occurred or the first symptoms of the illness appeared that are the reason for this claim:

_____ dd/mm/yyyy _____

Indicate the type of abnormalities and/or symptoms presented:

_____

_____

_____

_____

_____

_____

_____

_____

Indicate the diagnosis that is the reason for your claim (as indicated by your attending physician):

If this is an accident, please provide details of how and where it occurred:

Did any authority become aware of the accident? Yes ☐ No ☐

In the case of a motor vehicle accident, do you have automobile insurance? Yes ☐ No ☐

If yes, please complete the following information:

Company Name: _____

Policy No.: _____

Third Party's Company: _____

Were you hospitalized? Yes ☐ No ☐ Length of stay (days): _____

Hospital Name: _____

Have you previously submitted expenses for this condition or accident to this or another company?

Yes ☐ No ☐

If yes, please complete the following information:

Claim No.: _____ Company: _____

Claim Date: _____ dd/mm/yyyy

Do you currently have another Health Insurance policy? Yes ☐ No ☐

Specify which one: _____

D. Information on Physician(s) Consulted.

Attending Physician's Name: _____

Specialty: _____ Hospital Name: _____

Office Telephone: _____ Mobile: _____

Mail: _____

Address: _____

Date of Initial Consultation with this Physician: _____ dd/mm/yyyy Hospitalization Date: _____ dd/mm/yyyy

Name and telephone number of family or primary care physician:

E. Payment Instructions.

I hereby request and authorize Prevem Seguros S.A. de C.V. to make any payment due to me under the insurance contract entered into with this insurer according to the following information:

☐ Electronic Transfer ☐ Check

Bank Name: _____

CLABE: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Note: If this claim is approved for payment, it will be made in the name of the policyholder; the bank account indicated must belong to the policyholder.

"The Insured" agrees that upon payment of the "Indemnity," all benefits that could be claimed from PREVEM Seguros, S.A. de C.V. in connection with the claim identified above shall be deemed fully satisfied. The parties agree that upon delivery of the corresponding payment, whether (i) by check, from the time of delivery, with "The Insured" being responsible for cashing it, or (ii) by electronic transfer upon delivery of the confirmation, this instrument shall serve as a Full and Final Settlement Receipt. "The Insured" therefore declares under oath that, having received the payment, no present or future legal action or right of any kind—civil, criminal, labor, tax, administrative, or otherwise—remains to be exercised against PREVEM Seguros, S.A. de C.V., or against its employees, attorneys-in-fact, legal representatives, workers, service providers, officers, or affiliates, arising from "The Claim" or "The Policy" identified herein, with respect to the claim submitted, and hereby grants the broadest settlement and release permitted by law, since the claim has been satisfied in full and no amount remains owed.

F. Documentation and Signatures.

1. Copy of the public prosecutor's report or the care received from the institution (in the event of an accident on a public road).
2. Interpretation of radiological or diagnostic imaging studies.
3. Copy of official identification of the affected insured (IFE, passport, and for children under 5 years of age, birth certificate).
4. Expense receipts meeting tax requirements and bank statements (copies, provisional receipts, etc. will not be valid).
5. Each attending physician must complete the corresponding medical reports and indicate their participation in the event.

Authorization

You are hereby informed that any inaccurate or false statement provided in this form releases Prevem Seguros S.A. de C.V. from all liability. I authorize the physicians who have treated or examined me, the hospitals, clinics, sanatoriums, laboratories and/or healthcare facilities I have attended for treatment and/or diagnosis of any illness, accident or injury, and the judicial or administrative authorities that have been involved in my case, to provide Prevem Seguros S.A. de C.V., even without a judicial or administrative order, with all information concerning my personal medical history, clinical history, medical instructions, laboratory and diagnostic imaging results, and any information contained in my medical record. Such information may be requested at any time Prevem Seguros S.A. de C.V. considers appropriate, including after my death.

By this authorization, I release from any liability arising from medical confidentiality the persons responsible for providing the requested information. I also authorize the insurance companies to which I have previously applied for any insurance contract or insurance application to provide Prevem Seguros S.A. de C.V. with information in their possession, and authorize Prevem Seguros S.A. de C.V. to provide any other company in the insurance sector with any information requested that arises from this document and from other information in its possession.

Name and Signature of the Policyholder or Contracting Party	Name and Signature of the Affected Insured (If a minor, signed by either parent)
Date: dd/mm/yyyy	Place: