BUPA CORPORATE CARE MEDICAL SUPPLEMENT

Bupa retains the right to contact the applicant if any question is not explained in detail or if additional information is required.

Group name		Group ID	

A. MEDICAL INFORMATION

1. Applicants (Member and dependents)

Applicant		Date of birth	MM / DD / YY
Doctor's name	Specialty	Tel. number	
Applicant		Date of birth	MM / DD / YY
Doctor's name	Specialty	Tel. number	
Applicant		Date of birth	MM / DD / YY
Doctor's name	Specialty	Tel. number	
Applicant		Date of birth	MM / DD / YY
Doctor's name	Specialty	Tel. number	

If more space is required, please use an additional sheet, signed and dated. If completed, please check here to confirm. ☐

2. Medical check-ups

Has any applicant had any pediatric, gynecological, or routine examination in the past five years? ☐ Yes ☐ No
If "Yes", please explain below.

Applicant	Type of exam	Date
		MM / DD / YY

Result:	If abnormal, please describe.
☐ Normal ☐ Abnormal	

Applicant	Type of exam	Date
		MM / DD / YY

Result:	If abnormal, please describe.
☐ Normal ☐ Abnormal	

Applicant	Type of exam	Date
		MM / DD / YY

Result:	If abnormal, please describe.
☐ Normal ☐ Abnormal	

If more space is required, please use an additional sheet, signed and dated. If completed, please check here to confirm. ☐

3. Medical conditions		
Has any applicant ever had...		
a	infections?	☐ Yes ☐ No
b	vision, ear or hearing, nose or throat disorders?	☐ Yes ☐ No
c	seizures, migraine, paralysis, or other neurological disorders?	☐ Yes ☐ No
d	heart disorders, circulatory disorders, high blood pressure, high cholesterol, or high triglycerides?	☐ Yes ☐ No
e	allergies, asthma, bronchitis, or other pulmonary disorders?	☐ Yes ☐ No
f	esophagus, stomach, intestines or pancreas diseases, hepatitis, other liver diseases, or other digestive disorders?	☐ Yes ☐ No
g	kidney or urinary tract diseases?	☐ Yes ☐ No
h	spinal column problems, rheumatism, arthritis, gout, or other muscle, joint or bone disorders?	☐ Yes ☐ No
i	cancer or benign tumors?	☐ Yes ☐ No
j	anemia, leukemia/lymphoma, or other blood disorders?	☐ Yes ☐ No
k	diabetes, thyroid gland disorders, or other endocrine/hormonal disorders?	☐ Yes ☐ No
l	prostate disorders?	☐ Yes ☐ No
m	sexually transmitted diseases, sexual organs diseases, or other reproductive disorders?	☐ Yes ☐ No
n	breast, ovaries/uterus disorders, or other gynecological disorders?	☐ Yes ☐ No
o	skin disorders?	☐ Yes ☐ No
p	congenital or hereditary disorders?	☐ Yes ☐ No
q	any other disease, disorder, illness, injury, accident, surgery, pending surgery or hospitalization not mentioned above?	
If you have responded “Yes” to any of the above, please explain below.		

4. Medical conditions explanation				
Letter	Applicant	Condition	From	To
			MM / DD / YY	MM / DD / YY
Treatment and results			Current state of health	
Doctor’s name			Doctor’s tel. number	
Letter	Applicant	Condition	From	To
			02/04/2020 YY	MM / DD / YY
Treatment and results			Current state of health	
Doctor’s name			Doctor’s tel. number	
Letter	Applicant	Condition	From	To
			02/04/2020 YY	MM / DD / YY
Treatment and results			Current state of health	
Doctor’s name			Doctor’s tel. number	
If more space is required, please use additional sheet, signed and dated. If completed, please check here to confirm ☐				

5. Medications

Is any applicant currently taking medication, or been advised at any time to take any medication? ☐ Yes ☐ No
If "Yes", please explain below.

Applicant	Name of medication	Reason
xcvxzcv	xcvxcv	xzcvxcv

Amount	Frequency	From	To
		MM / DD / YY	02/04/2020

Applicant	Name of medication	Reason
		xzcvxcv

Amount	Frequency	From	To
		MM / DD / YY	MM / DD / YY

Applicant	Name of medication	Reason

Amount	Frequency	From	To
		MM / DD / YY	MM / DD / YY

Applicant	Name of medication	Reason

Amount	Frequency	From	To
		MM / DD / YY	MM / DD / YY

If more space is required, please use additional sheet, signed and dated. If completed, please check here to confirm. ☐

6. Habits

Has any applicant ever smoked cigarettes or consumed nicotine products, alcohol or illegal drugs? ☐ Yes ☐ No
If "Yes", please explain below.

Applicant	Type	Amount per day

7. Family history

Does any applicant have a family history of diabetes, hypertension, cancer, or a congenital or hereditary cardiovascular disorder? ☐ Yes ☐ No
If "Yes", please explain below.

Applicant	Relative with the disorder (please check)			
	Father	Mother	Sibling	Child
	☐	☐	☐	☐

Disorder

Applicant	Relative with the disorder (please check)			
	Father	Mother	Sibling	Child
	☐	☐	☐	☐

Disorder

B. ACKNOWLEDGEMENT AND AUTHORIZATION

I certify that I have read and reviewed all the answers and statements declared in this Medical Supplement and that to the best of my ability, they are complete and truthful. I understand that any omissions, incorrect or incomplete statements could cause claims to be denied, and the policy to be modified, cancelled, or rescinded. If any member requires medical care or treatment after the Member Enrollment Form and Medical Supplement are signed, but before the effective date of this membership, I will provide full details to Bupa for final approval before coverage is effective. I agree to accept my membership in this Group Policy with the terms and conditions as issued. I hereby authorize the Group Administrator to receive my Membership Guide, Membership Certificate, and all documents related to my insurance coverage.

Authorization to Collect Health Information

I hereby authorize Bupa Insurance Company and its Miami subsidiaries and affiliates (collectively "Bupa") to request my and/or my dependents' protected health information including, without limitation, my and/or my dependents' medical records, any prescription medication records/history, treatment records or plans, and any other medical or pharmaceutical information to be considered in the underwriting decision upon my and/or my dependents' application. I hereby authorize any physician, hospital, lab, pharmacy, or any other health care provider, health plan, employer/group policyholder or benefit plan administrator, the Medical Information Bureau (MIB), and any other organization or person, including any member of my family having access to any medical records or knowledge of myself or my health, to disclose such information to Bupa, its Business Associates, or its designated agents (collectively, "Bupa Entities").

The existence of any such information and documentation as described above shall be disclosed under this application. I understand that Bupa Entities will rely on such information to 1) underwrite this application for coverage and make eligibility, risk rating, policy issuance, and enrollment determinations for all of the applicants; 2) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 3) administer coverage, and 4) conduct other insurance operations according to applicable law.

I understand that Bupa's ability to underwrite the insurance is dependent upon the receipt of all necessary health information. As such, my refusal to provide authorization (marking "No" below) will result in the rejection of my application for enrollment.

☐ Yes ☐ No

Authorization to Disclose Health Information

I hereby authorize Bupa Insurance Company and its Miami subsidiaries and affiliates (collectively "Bupa") to use and disclose my policy conditions, certificate of coverage, and other insurance documents, payment information, claims filings, and medical records which may contain protected health information, to the Group Administrator appointed for my Group. I understand that the Group Administrator's use and disclosure of my protected health information is limited through the Group Plan documents, as required by the Health Insurance Portability and Accountability Act (HIPAA).

☐ Yes ☐ No

I understand that:

• Bupa will use any information supplied in this application and received through this authorization prior to the effective date of coverage in considering my application. • Bupa will comply with the Health Insurance Portability and Accountability Act of 1996 as amended and supplemented and the regulations thereto (HIPAA) and that the use and disclosure of information will be done under the applicable HIPAA statute and rules. • I am entitled to receive a copy of this authorization. • A copy of this authorization shall be as valid as the original. • The authorization shall be valid for the complete term of the coverage, including automatic renewal. • This is a voluntary authorization, and that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipients and no longer protected under HIPAA. • I have the right to revoke this authorization by notifying Bupa in writing and subject to and in accordance with 45 C.F.R. §164.508. However, the revocation will not be effective until Bupa receives and processes such revocation. Revocations shall be sent by postal or electronic mail to:

Bupa Privacy Office: 17901 Old Cutler Road, Suite 400, Palmetto Bay, Florida 33157 USA
Privacyoffice@bupalatinamerica.com

I have reviewed and understand the content and purpose of this acknowledgement and authorizations. By signing or replying affirmatively, I am confirming that the authorization decisions noted above accurately reflect my wishes. My signature below constitutes acceptance of all items listed above.

C. SIGNATURES

Member's signature		Date	MM / DD / YY
Member's printed name			
Spouse's signature		Date	MM / DD / YY
Spouse's printed name			

As Group Administrator, I accept full responsibility for the submission of this Medical Supplement, sending all the premiums, and for the delivery of the Membership Certificate when issued. I do not know of any condition that has not been disclosed in this Medical Supplement that may affect the insurability of the applicants.

Group Administrator's signature	Group Administrator's printed name