SEGUROS SALUD GLOBAL

CLAIM FORM

This claim form must be completed by Salud Global insureds.

IMPORTANT INFORMATION

If you have more than one invoice, it is not necessary to send separate claim forms. Send the invoices with a letter explaining the diagnosis, illnessor accident and payment instructions. In case that the diagnosis, illness or accident treatment extends for more than six months, we may require a new claim form. We cannot return the original documents to you. However, we can provide copies if needed.
In case we request additional information to assess your claim, please remember that your policy has a filing limit of 4 years. To avoid denial of your claim, please submit the requested information within the filing limit.

1. POLICYHOLDER INFORMATION

Name		RUT/Passport Nº	

2. PATIENT INFORMATION - TO BE FILLED OUT BY THE POLICYHOLDER

Policy Number | **Folio Number**

Title		RUT/ Passport Nº	
Name			
Last Name			
Mother's Maiden Name			
Other Names			
Date of Birth		Age	

Mailing address

Building/House	
Street	
Commune	
Area Code	Zip Code
City	
Country	
E-mail	
Telephone Number	Isapre

Is this your permanent residence address? Yes ☐ No ☐

Would you like all future correspondence to be sent to this address? Yes ☐ No ☐

Do you have a residence address in the United States? Yes ☐ No ☐

Country in which the medical service was provided:

Billing currency: Amount of total charges:

3. MEDICAL INFORMATION - THIS SECTION MUST BE FILLED OUT BY THE PATIENT'S TREATING PHYSICIAN

Physician Information

Name	
Address	
Specialty	
Diagnosis	

Continuation of treatment Yes ☐ No ☐

Date of first symptoms	
When did the patient first see a pysician in reference to this claim?	

In case of accident	Date of accident		Location of accident	

Details of treatment	
Details of surgery	
Details of prescribed medication	

Dental treatment

☐ Annual check-up ☐ Preventive ☐ Major restoration ☐ Orthodontics ☐ Emergency treatment or due to accident

Details of dental treatment	

Hospitalization dates: Admission date | Discharge date

Name and address of the admitting hospital: Reference number

Name	
Address	

Telephone number		Fax	
E-mail			

Signature and stamp of dental surgeon/physician	Date

4. PAYMENT DETAILS

IMPORTANT INFORMATION

PLEASE FILL OUT SECTION “A” OR SECTION “B”

Section “A” - Reimbursement in Chile

¿En qué moneda desea que realicemos el reembolso? (por favor seleccione sólo una opción a continuación)

☐ Deposit in Bank Account ☐ Bank Check

The reimbursement will be done in Chilean pesos.
Account deposits must be carried out in a bank.
Bank checks are issued by BBVA Bank, at the customer service counter located in any bank within Chile.
In the case of an account deposit, please fill out the information below.

Name of bank	
Account number	
E-mail	

Reimbursement deposits shall be made into the account of the insured party.

Section “B”: Reimbursement abroad (only in American dollars)

Name of bank			
SWIFT/BIC code			
Account number			
IBAN*			
Bank address			
Area zip code		Country	

*** With the purpose of facilitating the reimbursement process, please include your bank branch’s SWIFT and IBAN codes. If necessary, your bank can provide you with this information.**

In case we are unable to process a reimbursement directly into your bank account, or that your account details are not provided, the reimbursement shall be sent by check through regular mail, to the correspondence address specified on the first page. We reserve the right to send payment to the corresponding person, for example, the representatives in charge of executing a will for an insured who has passed away or the dependent in your policy who has paid the premium.

5. CONFIDENTIALITY

IMPORTANT INFORMATION

In order to process your claim, it may be necessary to request a medical report from your physician. Therefore, we require your written consent by signing the following statement.
You may choose from one of the three following options:
1. You may give us consent without the need to review the medical report beforehand. The report shall be sent by your physician directly to Seguros Bupa.
2. You may give us consent requiring to review the medical report before it is sent to Seguros Bupa, in which case you are granted 21 days to do so from the date in which Seguros Bupa requests the revision of the report. If you do not contact your physician within 21 days of our notification, he/she has the authority to directly send us said report. If, on the contrary, you contact your physician in order to have access to your medical report, you must provide your physician with written consent so that he/she sends said report to us.
You may ask your physician to change the report if you consider the information to be confusing. If your physician refuses to do so, you may insist and add your own comments in the report before it is sent to Seguros Bupa.
In case that you decide to grant us consent without indicating if you wish to review the medical report before it is sent to Seguros Bupa and then you change your mind, you may contact your physician before said report is sent to Seguros Bupa, in which case you may review it and ask your physician to make any changes or add any comments before it is sent, or not grant your consent for said report to be revealed.
3. You have the right to refuse consent so that your medical report will not be shared, in which case your claim may be denied.
Regardless of your decision to have access to your medical report before it is sent to Seguros Bupa, you have the right to ask your physician for a copy of said report if you request it within the first six months after the report was sent to us.
Your physician has the authority not to reveal, either partially or totally, the information included in the report if: (a) he/she considers it would be harmful to you, or (b) said information reveals his/her intentions with you, or (c) said report reveals the identity of another person without his/her consent (which is dierent than what is permitted by a health specialist within a professional context and with regards to your care). Your physician may request reasonable fees for the services provided.
With my signature below, I authorize and request any hospital, clinic, specialist, physician or other health care worker to provide Seguros Bupa or a duly authorized agent acting as a representative for Seguros Bupa, all the information Seguros Bupa or said agent may need regarding any treatment or other services provided to myself or my dependent so that Seguros Bupa considers reimbursement for this claim.
I have been notified of my rights under Law 19.628 regarding the protection of my personal information and under Article 127 of the Health Code.
Please mark here if you wish to have a copy of your medical report before it is sent to Seguros Bupa:

Yes ☐

No ☐

NOTIFICATION OF DATA PROCESSING

Purpose: The personal information gathered about you and your dependents covered under this policy may be used by Seguros Bupa to process your claims, manage your policy, make suggestions about the clinically appropriate treatment, for investigation and analysis, and to detect and prevent fraudulent or inappropriate claims.

Confidentiality: The confidentiality of the patient or insured's information is of the utmost concern for Seguros Bupa. Therefore, Seguros Bupa complies with the corresponding legislation and medical confidentiality guidelines.

Medical Information: Your medical information shall remain confidential. Your medical information shall only be shared with the parties involved in your care or treatment, unless it is required or legally permitted. This includes your primary physician and agents, and if it were necessary, any person, organization who are responsible for your treatment expenses.

The information may also be shared with third parties who participate in the management of your policy and this process. The information may be shared with Seguros Bupa or your insurance agent if you have requested their assistance.

The exchange of personal information: Considering our confidentiality obligations and data protection, we may share your personal information with:

• Other Seguros Bupa aliates for the aforementioned purposes; however, access is restricted to only the people who need the information for these purposes.

• Other Seguros Bupa aliates or our insurance partners. If you transfer to another Seguros Bupa insurance policy or an insurance policy oered by one of our associates, we may share your health information and claims with the new insurance company.

• Our service providers.

• Sometimes it may be necessary to share your personal information with professional consultants such as claim investigators, paramedics, physicians, lawyers and other experts.

We also hire service providers for information technology, printing, marketing services, investigation, analyses and similar services. In each case, it is required that the service providers only have access to the personal information that they need in order to carry out their services. In the same manner, we may share information with the policyholder about the services received by other dependents covered by the policy, any claims that have been paid, how much of the deductible was covered and, if required, any medical records of any other dependent covered by the policy, which may have an impact on the benefits provided. In some cases, these consultants are located out of your jurisdiction, in countries that do not offer the same coverage that Chile oers. Seguros Bupa ensures that they are subjected to contract restrictions with regards to security and confidentiality obligations.

Details about the insured: Policy documents and correspondence related to any claim may be sent to the policyholder. Seguros Bupa may share other information with the policyholder such as, for example, the benefits received by other dependients covered under the policy, paid claims, amount of deductible that has been covered, and if necessary, the medical records of any dependent covered under the policy, that may aect the provision of benefits.

Telephone calls and online chats: With the purpose of continually improving our services, your call or online chats will be recorded and may be monitored.

Investigation an analysis: Your personal information may be used for analytical purposes, statistics and research. The results shall be used to develop and improve our services and the services you receive financed by your Salud Global policy. We may also contact you to invite you to participate in research activities.

Fraud: We are bound by law, in certain circumstances, to share information with legal compliance agencies regarding suspicions of fraudulent claims and other crimes. We shall reveal information to third parties, including other insurers in order to prevent, detect and investigate crimes, including reasonable suspicion of inappropriate fraudulent claims.

Name and addresses: Seguros Bupa does not reveal the name and address of its policyholders or dependents to other organizations outside of the group and its service providers.

We shall keep you informed: Seguros Bupa may inform you about other Seguros Bupa services and products that may be of interest.

Check the box if you would like us to send updated information about our products and services:

☐

You may choose to stop receiving said information at any time.

Contact address: In accordance with the data protection law, if you would like to receive a copy of your personal information (which may require you to incur in some expenses), request to update your personal information or have a question related to data processing, please contact the Seguros Bupa Service Team at +56 22 391 3300. You may also send us an e-mail to atencionsaludglobal@bupa.cl or reach us at:

Cerro El Colorado 5240, Torre Edificio del Parque II
Piso 12, Las Condes
Santiago de Chile

For more information, consult the Data Protection Notice at www.segurosbupa.cl

6. EXTERNAL INSURERS

May Seguros Bupa recover charges from third parties (for example, an insurance company or person / organization related to an accident)? Yes ☐ No ☐

Name	
Address	

7. AUTHORIZATION – TO BE COMPLETED BY THE POLICYHOLDER

I hereby declare that the information provided in this document is correct and precise to the best of my understanding. I confirm I have provided specific consent, within the Data Protection Act 1998, to process my personal information in reference to this claim.

Patient signature (Parent or Legal Guardian if the patient is 16 years old or younger)	Date