BUPA CORPORATE CARE
GROUP MEDICAL UNDERWRITING
(10 POLICY HOLDERS MINIMUM)

(PLEASE USE BLOCK LETTERS)

SECTION 1

Application and Authorization Declaration

I hereby request on behalf of the aforementioned company a business group plan. I agree that the rules of the business group plan will be binding on the company mentioned in the proposal, and I confirm that I am authorized to sign this form and the contract on behalf of the company.

I declare that all main members who will be included in this plan are employees of the company, who are eligible to join the plan. I declare that, to the best of my knowledge, the information given in this form is true and complete. I understand that the act of omission or providing false or misleading information may result in cancelling the insurance and preventing the payment of claims made by the members of the group. In such circumstances, Bupa reserves the right to cancel a group member's policy and/ or the company's group plan (as applicable).

I declare that the employees of the company, whose information is included in this document, have given to the company their consent/ authorization to share with Bupa the personal information of those, to be considered insured principals, and also to share with Bupa the personal information of their respective dependents, so that all the personal information referred to above is processed by Bupa for risk assessment purposes in the issuance and/or renewal of a group plan health insurance policy that we request is issued (or that is already issued), on the name of the company that I represent.

I am aware that regarding serious pre-existing conditions (see listing in Section 2, Question 1) that have not been declared in this form, their local and international coverage will be permanently excluded from the policy.

The quotes are based on the census information and the information provided in this form. I understand that, If any serious illness develops after this form is signed but before the start date of the policy, the medical evaluation process could result in the adjustment of premiums.

By signing and submitting this form, you acknowledge your acceptance and your consent for Bupa to use any information you are providing, including personal information, to fulfil the services to which the application relates. You accept and consent to Bupa using such personal information in agreement with the terms of its Privacy Notice available on https://www.bupasalud.com/en/privacy-policy. You acknowledge that if you are sharing other individuals' personal information with Bupa (such as individuals you are representing, individuals to be covered by a corporate insurance product, or any dependents) you have the authority to act on behalf of those individuals, and that they have given you their express acceptance and consent to the terms of our Privacy Notice available on https://www.bupasalud.com/en/privacy-policy for the use of their personal information as described therein and as required to fulfil the services for which you are applying.

I hereby authorize Bupa Insurance Company and its Miami subsidiaries and affiliates (collectively referred to as "Bupa") to use and disclose medical records which may contain protected health information to my insurance agent/agency. I understand as the Group administrator/ secretary that such protected health information is limited to Group Plan documents, in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of the United States of America. The authorization shall be valid for the complete term of the coverage, including automatic renewal.

Company name		Date	
Group administrator's first name and last name			

SECTION 2

Group Medical Underwriting (GMUW)

Please note that group members who are 70 years of age or older cannot be included in this form and will need to go through the individual medical evaluation process

1. Do you know if any of your employees and/ or dependents to be covered by the plan have a current and past history of any of the following medical conditions? If any of the answers is yes, please complete the next section of the form. 3.A • Cirrhosis • Diabetes Mellitus Type 1 • Type 2 Diabetes with complications in other organs • Muscular Dystrophy • Amyotrophic Lateral Sclerosis • Multiple Sclerosis • Cystic Fibrosis • Advanced Chronic Kidney Disease • Systemic Lupus Erythematosus • Myasthenia Gravis • Multiple Myeloma • Morbid Obesity • Chronic Pancreatitis • Some type of cancer, including benign brain tumors, malignant tumors in treatment and/ or metastases	☐ Yes ☐ No
2. Does any employee and/or dependent have a current and past history of disability to the point of not being able to execute common tasks? If the answer is yes, please, complete the next section of the form. 3.B	☐ Yes ☐ No

SECTION 2 (CONT.)	
3. Has any of your employees and/or dependents incurred medical expenses above $20,000 over the past 2 years? If the answer is Yes, please, complete the next section of the form. 3.C	☐ Yes ☐ No

SECTION 3

3.A- Medical condition details for each employee and/or dependent. Please identify on a case-by-case basis.

	Applicant's first name and last name	Description of the medical condition	Number of cases with this diagnosis	Year of occurrence
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

3.B- Disability details for each employee and/or dependent. Please identify on a case-by-case basis.

	Applicant's first name and last name	Description of the disability	Start date	Prognosis
1				
2				
3				
4				
5				

3.C- Details of medical expenses above $20,000 over the last 2 years for each employee and/or dependent. Please identify on a case-by-case basis.

	Applicant's first name and last name	Description of medical expenses	Number of cases of diagnosis	Amount in USD claimed
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
Name of Contracting Company			Date	
Name and last name of Group administrator				

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Completing this document does not imply acceptance of risk.