Grupo Nacional Provincial, S.A.
Av. Cerro de las Torres 395, Col. Campestre Churubusco
C.P. 04200, Mexico, D.F. Tel: 5227 3999
www.gnp.com.mx

Medical Expenses

Notification of accident or illness
(Refund, programming of services and/or medical treatment)

This form must be completed with correct and detailed information, and be signed by the Insured. Submission of this form does not mean that the Company is required to admit the validity of the claim, nor waive the rights reserved under the policy. This document shall not be valid if it has any deletion and/or erasure.

Policy No.	Date (month / day / year)

I. Details of Policy Holder

Paternal Surname | Maternal Surname | Name(s) | Customer's code or certificate number

Tax # (Letters / Year / Month / Day / Code (if any)) | Unique citizen's registration number (if any) | Sex ☐ F ☐ M | Nationality (other than Mexican)

Marital status ☐ S ☐ M ☐ D ☐ W ☐ CL | Current occupation | Type of business

Does the Insured party or has the Insured Party held any position in the state or federal government the last four years? ☐ Yes ☐ No Position | e-mail (if any)

Private Address

Street | No. | Apartment No.

Precinct | Zip Code

Municipality or District | City or Town | State | Country | LD code / Telephone number

II. Details of the Insured Party affected (if not the Policy Holder)

Paternal Surname | Maternal Surname | Name(s) | Customer's code or certificate numbers

Tax # (Letters / Year / Month / Day / Code (if any)) | Occupation | Relation with policy holder | Sex ☐ F ☐ M | Marital status ☐ S ☐ M ☐ D

Private Address (if not the Policy Holder's)

Street | No. | Apartment No.

Precinct | Zip Code

Municipality or District | City or Town | State | Country | Long distance code / Telephone number

Place at which treatment was given

State | Municipality or District

III. Details of the contracting individual (if not the Policy Holder)

Paternal Surname | Maternal Surname | Name(s) | Customer's code or certificate numbers

Tax # (Letters / Year / Month / Day / Code (if any)) | Unique citizen's registration number (if any) | Sex ☐ F ☐ M | Nationality (other than Mexican)

Current occupation | Type of business | e-mail (if any)

Does the Insured party or has the Insured Party held any position in the state or federal government the last four years? ☐ Yes ☐ No Position | Relation with applicant

Contractor (if a company)

Corporate Name | Customer Code (if any)

Tax # (Letters / Year / Month / Day / Code (if any)) | Line of business or corporate purpose | e-mail or website (if any)

Name of legal representative

Paternal Surname | Maternal Surname | Name(s)

Address of contracting party (individual or company)

Street | No. | Apartment No.

Precinct | Zip Code

Municipality or Delegation | City or Town | State | Country | Long distance code / Telephone number

Have you previously claimed expenses for this condition with this or another company? Type of claim ☐ First ☐ Complementary	Claim Number
For ☐ Accident ☐ Illness ☐ Pregnancy	Specify the diagnosis on which your claim was based
If accident, please specify how and when it occurred	Date of accident or beginning of condition month day year

In the event of a traffic accident, was the vehicle insured? ☐ Yes ☐ No	Name of the Company	Coverage	Insured Sum	Policy Number

Attach a copy of the police report or proof and/or the report from the Company, and the interpretation of studies made.

Hospital to which you were admitted	Details of programmed admission time month day year

Physician's Name	Specialty	Does the hospital have an agreement with the Company? ☐ Yes ☐ No

Through which medium was your physician refereed?

☐ GNP Seguros ☐ Hospital ☐ Other

I hereby declare that all information included on this document is true and that it coincides with the medical record of which I am aware and that I shall be liable for any consequences.

Name and signature of the Insured Party and/or Policy Holder

Agent's Name	Code	Telephone Number	State

Asistencia Linea Azul

We can provide you the following benefits 24 hours a day, 365 days a year

- Advice regarding how the policy works
- Information on physicians who are associates of the Medical Circleo.
- Free medical advice over the telephone, provided by Medica Movil
- Information regarding associate hospitals.
- Information regarding medical supplies that offer preferential rates.
- Information on the processing of your claim.

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