APPLICATION TO REQUEST REVIEW OF EXCLUSIONS AND/OR LIMITATIONS



BAF MedSafe Secure Care Plus & Critical Care 500 • Business Fit

Table appropriate distributed by the Police and PLOCK LETTERS					
To be completed by the Policyholder. Please use BLOCK LETTERS.					
1. POLICYHOLDER S INFORMA	ATION				
Name					
Policy Number					
Insured person to whom the exclusion and/or limitation applies.					
Text of the exclusion and/or limitation to be reviewed.					
2. (a) TREATING PHYSICIAN'S	INFORMATION		_		
Name					
Address					
Telephone			Fax		
Email					
Date of the last three (3) consulta	ations for whom the limita	ation and/or excluded condit	ion applies, and include	e recently updated medic	cal information
1) m/d/y		2)m/d/y		3) m/d/y	
Describe the current medical status of the insured to whom the limitation and/or excluded condition applies.					
Describe the current medical state	as of the moured to who	The initiation and, or exercise	aca condition applies.		
(b) TREATING PHYSICIAN'S INFORMATION					
Name					
Address					
Telephone			Fax		
Email			TUX		
Date of the last three (3) consultations for whom the limitation and/or excluded condition applies, and include recently updated medical information					
1) m/d/y		2)m/d/y	ion applies, and include	3)m/d/y	ai iiioiiiiauoii
				3) 111/ u/ y	
Describe the current medical status of the insured to whom the limitation and/or excluded condition applies.					
			_		
3. SIGNATURE					
I hereby certify that the above information is correct and true and understand that if misstated, any modification or change to the exclusion or limitation if granted will be rescinded. I am willing to provide BAF Financial and Insurance (Bahamas) Ltd. with any medical evidence considered necessary to evaluate the above-mentioned exclusion and/or limitation.					
Policyholder's Signature				Date	m/d/y