APPLICATION TO REQUEST REVIEW OF EXCLUSIONS AND/OR LIMITATIONS

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

To be completed by the Policyholder. Please use BLOCK LETTERS.

1. POLICYHOLDER S INFORMATION

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) consultations for whom the limitation and/or excluded condition applies, and include recently updated medical 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.

(b) TREATING PHYSICIAN'S INFORMATION

Name			
Address			
Telephone		Fax	
Email			

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	3)m/d/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and true and understand that if misstated, any modification or change to the exclusion or limitation if granted will be rescinded.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