

# APPLICATION TO REQUEST REVIEW OF EXCLUSIONS AND/ OR LIMITATIONS

(To be completed by the policyholder)



## 1. POLICYHOLDER'S INFORMATION

Last Name:	First:	M.I.:	Policy No.:
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## 2. INSURED PERSON TO WHOM THE EXCLUSION AND/OR LIMITATION APPLIES:

Last Name:	First:	M.I.:
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Number and Text of the exclusion and/or limitation to reviewed (as indicated on the certificate of coverage): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of the last three (3) consultations for the limitation and/or excluded condition:

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Day Month Year

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Day Month Year

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Day Month Year

Describe the current medical status of the insured to whom the limitation and / or excluded condition applies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 3. ATTENDING PHYSICIAN'S INFORMATION

Last Name:	First :	M.I.:	Telephone:
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Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby certify that the person to whom the exclusion and/or limitation applies has been free of symptoms and/or signs of the medical condition that originated the exclusion and/or limitation as of \_\_\_\_/\_\_\_\_/\_\_\_\_, and said person has not required any kind of medical treatment for such condition. I am willing to provide the Insurer with any medical evidence considered necessary to evaluate the above mentioned exclusion and/or limitation.

Main Insured Signature : \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Day Month Year