

# ACCIDENT / ILLNESS NOTIFICATION


 Policy number 

 Certificate number 

This questionnaire is answered and given to: **AIG México Compañía de Seguros de Vida, S.A. de C.V.**, in relation to a claim derived from the insurance contract of my Company:

## Name of the Titular Insured

Phone  ( LADA )  CURP or R.F.C.  Age   
 Mobil phone  E-mail

## Name of the Affected Insured

Paternal Name  Maternal Name  First Name   
 Relationship with the Insured  Age

## Address of the Affected one

Street and number  Country  Zip Code   
 Phone  ( LADA )  City  State   
 Mobil phone  E-mail

## Type of Claim

 To program surgery 

 Reimbursement 

 Direct Payment 

1) Date of the injury or Illness  Day /  Month /  Year Last work date  Day /  Month /  Year

2) Antecedents of the Illness

3) Accident. How and where did it occur?

Diagnosis Definitive

4) Hospital Name (only if you were hospitalized)  Days that it was interned

5) Since what date you were affected completely, disabled to work and unavoidably hospitalized?  
 Since the  of  20  TO the  of  20

6) If after this period you continued partially disabled to make the own tasks of your occupation, indicate for how long  
**Date disability began**  Day  Month  Year **Date disability ended**  Day  Month  Year

7) Has the Affected one some other insurance policy to protect accidents and Illness? Yes  No  In affirmative case, write the Name of that Insurance Company

8) Name of the Physician that takes care of you  Address  Phone

9) Other doctors that it has consulted during their suffering reason of this reclamation  
 Name  Address  Phone

The affected one (or their representative) authorizes to **AIG México Compañía de Seguros de Vida, S.A. de C.V.**, to inquiry to any Hospital or Physician for any injury or illness we suffered, such as History health file, consults, prescriptions and treatments, X- rays, and copies of the clinic file of the Doctors or of the hospitals. **REMEMBER THAT YOU SHOULD INCLUDE THE ORIGINALS OF THE VOUCHERS OR RECEIPTS OF THE EXPENSES.** This document will not be valid if it has crossing outs, deletions or scratches; and of the declared thing, later changes are not accepted.

Dated in  the day of

*Signature of the Affected Insured*

*Signature of the Titular Insured*

# Report of the Physician

1) Patient Name

Paternal Name  Maternal Name  First Name

2) Date of the first Examination Day / Month / Year    3) Date in that the first annoyances or symptoms appeared Day / Month / Year

4) Exact nature of the injury or illness, its development and diagnosis.

### Cause of the attention

Pregnancy   
Illness   
Accident

5) Definitive Diagnose

6) Describe the complications if there are them

7) This illness is related to some other suffering? YES  NO  Which?

8) Illness: 9) Has had the patient at some time the same or similar affections? In affirmative case, describe them

Is it congenital origin? YES <input type="checkbox"/> NO <input type="checkbox"/>	Is it acquired? YES <input type="checkbox"/> NO <input type="checkbox"/>	Is it acute sharp? <input type="checkbox"/>	Is it Chronic? <input type="checkbox"/>	<input type="text"/>
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Treatment recommended or prescribed

10) Please, write the dates that you attended to the patient Day / Month / Year	Home	Doctor's Office	11) If the patient was hospitalized serves you to mention dates Day / Month / Year	12) A surgery was practiced? YES NO	13) Please describe the nature of the surgery practiced or the treatment given.
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

14) Do you consider that the patient has been totally cured or there will be necessity to follow a new treatment?

15) In affirmative case, what type of treatment? How long will be the treatment?

16) Was the illness or injury so serious that disabled the person to make all the own tasks of the patient occupation?

YES  NO

17) In affirmative case, since what day you estimate that the patient has been disabled to carry out all and each one of his tasks?

Since  the  20  To  the  20

18) I after the period of total disability that refers the point 15, Do you estimate that the patient would be partially disabled to perform his own tasks? Please write the estimated dates.

Since  the  20  To  the  20

19) Other Physicians who attended the patient in this suffering.

Name	Address and phone
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

## Observations

Medical Net: YES  NO

## Physician Name

Paternal Name  Maternal Name  First Name   
Address  Phone   
Professional ID number  CURP or R.F.C.  *Signature of the doctor*   
Dated on  the  20

*Under protest to say truth, I declare that the information provided in this format was taken directly as much from the assured patient or from the relatives responsible, in the case of Minor or with different capacities. This information is in the file's patient, which I have in my possession.*