TRIPLE-S VIDA

P.O. Box 363786
San Juan, PR 00936-3786
Tel. 787.758.4888

EVIDENCE OF INSURABILITY – LIFE INSURANCE

Employee Name: ______________________________ Company Name: ______________________

Division and/or Department: __________________________ Social Security Number: ___________________

SECTION TO BE COMPLETED BY THE EMPLOYEE					
Name of Applicant:		Relationship to Employee:	Company Name (if different from above)		
Occupation:		Date of Birth (M/D/Y):	Gender:	Height:	Weight:
Annual Salary	Amount of Insurance Inforce:	Coverage Requested: ☐ Basic Life Insurance (amount): ____________ ☐ Supplementary Life Insurance (amount): ____________ ☐ Dependent's Insurance Coverage: ☐ Spouse (amount) ____________ ☐ Child (amount) ____________			

ALL QUESTIONS TO BE ANSWERED

YES	NO		
☐	☐	1.	Have you been treated or have you been informed that you have: a cardiac condition, heart murmur, high blood pressure, sugar, albumin, blood, pus in urine, cancerous tumor, alcohol or drug use, ulcers or other disorder of the stomach, disorder of the muscles or bones, including neck, back or joints, or respiratory disorders?
☐	☐	2.	Are you taking any medication regularly, if so, when and how often?
☐	☐	3.	Have you been advised of the need for treatment for an illness or the need for a surgical procedure which have yet to be performed?
☐	☐	4.	Have you been diagnosed, suffer or have a repeated illness caused by a virus, bacteria, fungus in the respiratory tract, stomach, intestines, skin, in the urinary or sexual organs, or central nervous system?
☐	☐	5.	Have you suffer or suffered persistent pain of members (membranes) or joints (similar to colds), long term (persistent) diarrhea, unexplained fevers, weight losses without identifiable causes, frequent night sweats, lymphatic gland inflammation?
☐	☐	6.	During the past five (5) years, have you been treated or visit a doctor for any reason, including regular checkups?
☐	☐	7.	During the past five (5) years, have you been hospitalized or have been resting in a sanatorium for observation, diagnosis, treatment, or surgery?
☐	☐	8.	Have you been declined for life, accident, and/or health insurance, or have you experienced any increases in premiums, or have you been declined re-instatement?
☐	☐	9.	Have you smoked cigarettes or any other tobacco products during the last 12 months?
☐	☐	10.	Have you been diagnosed, are or have been in treatment for immune deficiency syndrome (AIDS) or AIDS related complex (ARC)?

IMPORTANT – FOR EACH AFFIRMATIVE RESPONSE, PLEASE FURNISH THE FOLLOWING INFORMATION			
QUESTION NUMBER	**CONDITION AND CURRENT STATUS**	**DATE OF OCCURRENCE AND RECOVERY DATE**	**PHYSICIAN'S NAME & ADDRESS**

(CONTINUE AT REVERSE SIDE)

(A) Name and address of physician who can provide a complete medical history.

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(B) Approximate date of last visit to a physician: _______________________________

Reason for the visit: ☐ Regular Check-Ups ☐ Others: ____

Specify the results of your visit: ____

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IMPORTANT: ALL QUESTIONS MUST BE ANSWERED TO PROCESS YOUR APPLICATION. INCLUDE COMPLETE PHYSICIAN'S NAME AND OFFICE ADDRESS. CONTINUE ON A SEPARATE SHEET IF NEEDED.

I, ____ hereby certify that the information given in this application is complete and correct, and I understand that the approval is based on the statement and answers given by me. I understand that Triple-S Vida, Inc. reserves the right to request additional information concerning insurability other than that provided. I authorize the release of information about my person in compliance with the applicable Law.

ANTIFRAUD NOTICE

The Law No. 230 dated August 9, 2008, states: "Any person who knowingly presents false information on an insurance application with the intention of committing fraud, or, who presents, or helps present, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim due to the same loss or damage, commits a severe offense and will be sanctioned for each offense with a penalty of not less than five thousand dollars ($5,000), and not more than ten thousand dollars ($10,000) or penalty of imprisonment for a term of three (3) years, or both penalties. If aggravating circumstances exist, the imprisonment penalty could be increased up to a maximum of five (5) years; if extenuating circumstances exist, the imprisonment penalty could be reduced to a minimum of two (2) years".

______________________	____
Date	**Applicant's Signature**

AUTHORIZATION TO OBTAIN INFORMATION TO BE SIGNED AND DATED

I, ____, authorize the following persons or institutions that have records or information about me, my job and my health, to give such information to Triple-S Vida, Inc., and/or legal representatives of Triple-S Vida, Inc.: namely, any doctor, hospital, clinic or any other medical facility, insurance company, or other similar organization, institution, employer, group policyholder or plan sponsor.

I understand that the information given to Triple-S Vida, Inc. will be used to determine my eligibility for insurance coverage and payment of benefits. Triple-S Vida, Inc. may disclose such information for this purpose to the employer or plan sponsor of the group insurance coverage, to their representatives, to any reinsurer or to any person or entity performing a business or legal function on behalf of Triple-S Vida, Inc. The information can be disclosed in any way specifically permitted or required by law.

This authorization is extensive and includes any information related to the use of alcohol and drugs, or care for mental conditions. This authorization or a copy will be valid for two ½ years from the date it is signed, except where different time periods may be required by applicable law.

The information disclosed to Triple-S Vida, Inc. cannot be re-disclosed by Triple-S Vida, Inc. to any person or institutions that are not mentioned above. I understand I have the right to have a copy of this application if I ask for one.

________________________________	________________________________
Applicant	Applicant's Signature
________________________________	________________________________
Social Security Number	Phone Number
________________________________	________________________________
Place and Date	Postal Address