TRIPLE-S VIDA

CLAIM NOTIFICATION FOR GROUP INSURANCE

Instructions

1. Part 1 to be completed by Claimant.
2. Part 2 to be completed by Group.
3. Please include the following documents with your claim:
   - ✓ Death Certificate (Original)
   - ✓ Birth Certificate of Insured and Beneficiaries
   - ✓ Marriage Certificate
   - ✓ Beneficiary Designation Form

Notice

"Any person that knowingly and with the intention to defraud submits false information in an insurance application or, submits, help or make submits a fraudulent claim for a payment of a loss or any other benefit, or submits more than one claim for the same loss, hill incur in a heinous crime and hill be guilty, and sanction by each violation with a minimum penalty of five thousand ($5,000) dollars, non greater than ten thousand ($10,000) dollars or a reclusion penalty of three (3) years in a penalty of three (3) years in a permanent term, or both penalties. To intercede aggravating circumstances, the permanent established penalty can be increased up to five (5) years; if intercede lessening guilt, can be reduced to a minimum of two (2) years." Law No. 18 dated January 8th, 2004.

Part 1: CLAIMANT'S Statement

1. Name of Insured:

2. Date of Death: | 2b. Date of Birth:

3. Name of Employer:

4. Occupation: | 4b. Social Security:

5. Last Dated Worked:

6. If the employee was not performing at work on the date of death, explain: | 6b. Cause of death:

CERTIFICATION

I hereby certify that I am the claimer under this Proof of Death, that the statement above are true and complete and the above named deceased is the person insured under the policy mentioned above. I further agreed that the furnishing of claim form by the Company shall not be considered an admission by the Company that there was any insurance in force on the deceased or a waiver of any of the Company's right or defense.

7. Claimant's Name

8. **Claimant's Signature** | 8b. Date

9. Phone No. | 10. Age | 11. Relation with Insured

12. Address | Urb., PO Box, HC, RR | Number / Street

City | State | Zip Code

13. Witness (if claimant signed with X)

CONTINUE ON REVERSE

Authorization to Obtain Information

Name of Insured: ____ Relation: _________________________________

To all physicians; hospitals; clinics or medical facilities; record keeper or person who had any record or knowledge of the insured or his health, to transfer to **Triple-S Vida, Inc.,** the information. A photocopy of this authorization and confirmation will be as valid as the original.

____ ____

Signature Date

Notice

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Part 2: EMPLOYER Statement

1. Name of Employer			
2. Address of Employer			
City		State	Zip Code
3. Name of Employee			
4. Occupation:		4b. Policy No.	
5. Monthly Salary:		5b. Employee's No.	
6. Date of Hired:		6b. Last Date Worked:	

7. If the employee was not performing at work on the date of death, explain:

Active ❐ Sick Leave ❐ Shutdown ❐ Vacations ❐ Absent due to leave of ❐

Totally Disabled ❐ Personal Absent ❐ Suspension ❐ Retired ❐ Absent ❐ Unemployment ❐

Other (explain) ❐ ____

8. Basic Amount	8b. Accidental or Dismemberment	8c. Supplementary	8d. Spouse/Child Insurance
$	$	$	$

9. Beneficiary Name	9b. Relation with Insured
10. Comments	

CERTIFICATION

I certify that the information submitted in this form is correct. I read the Notice of Fraud above and understand the penalties of fraudulent claims.

11. Name:	11b. Position
12. Signature	12b. Date