TRIPLE-S VIDA

CLAIM FORM

ACCIDENTAL RIDERS

(HOSPITALIZATION, EMERGENCY TREATMENT AND DESMEMBERMENT)

Policy No.

Insured Name			SS# / /
Patient Name			SS# / /
Patient's Date of Birth (m, d, y)	Sex: ❒ M ❒ F	Relationship	
Phone No. ( )	Cell Phone No. ( )	E-mail	
Postal Address			
Residential Address			

PATIENT INFORMATION

1. Diagnostic, what condition was diagnosed?
2. When the accident occurred? M_____ D_____ Y_____
3. When was your first doctor's visit for this condition? M_____ D_____ Y_____
   (Enclosed first emergency treatment invoice, if apply)
4. How and where the accident occurred?
5. Please enclosed Police Report, if apply.
6. Have you visited other doctors during the past three years? ❒ Yes ❒ No
   If you answered affirmative, please indicate the names, specialties and diagnostics:

NAME	SPECIALTY	DIAGNOSTIC	DATE OF SERVICE (m, d, y)
a.			
POSTAL ADDRESS			PHONE NUMBER AND ( )
b.			
POSTAL ADDRESS			PHONE NUMBER AND ( )
c.			
POSTAL ADDRESS			PHONE NUMBER AND ( )

7. Have you been hospitalized during the past three years? ❒ Yes ❒ No
   If you answered affirmative, please indicate hospital names, hospital period and diagnostics:

HOSPITAL NAME	HOSPITALIZATION PERIOD	DIAGNOSTIC

8. Do you continue under treatment? ❒ Yes ❒ No Explain: _____
9. If your dependent child under 21 years old is the claimant, please include Student Certification.
10. Civil status of your dependent child: ❒ married ❒ unmarried ❒ separated

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, will incur in a heinous crime and will be guilty, and sanction by each violation with a minimum penalty of five thousand ($5,000) dollars, non greater that ten thousand ($10,000) dollars or a reclusion 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 230 of august 9, 2008.

_____ Signature

_____ Date

DO YOU WANT TO RECEIVE FAST AND SECURE PAYMENTS?

❒ I request payment only by check. I am cancelling any previous authorization for automatic deposit to my account.
❒ I am notifying that my bank account number has changed.

Authorization for Electronic Payments to Claimants

Please provide a voided check or deposit slip.

I hereby AUTHORIZE Triple-S Vida to initiate credit entries to my account for the payable amount of the benefits claimed in the policy issued by Triple-S Vida, Inc., in which I am Policy Owner or Beneficiary. I should submit, in writing thirty (30) days in advance, the cancellation of this authorization or any change to the account information.

_____ Name and Branch of the Bank

_____ Route and Transit Number

_____ Bank Account Number

_____ Name of the Account Holder

Account Type: ☐ Check ☐ Savings

_____ E-mail

_____ Authorized Signature

_____ Authorization Date

☐ I authorize Triple-S Vida, Inc., to send the payment notice to my email.

TRIPLE-S VIDA, INC.
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MEDICAL STATEMENT

Patient Name:	Age	Diagnostic:

Date of Accident: M_____ D_____ Y_____ If there was any fracture, it was verified with X-rays? ❒ Yes ❒ No

First visit date: M___ D___ Y___ Time: _____ ❒ am ❒ pm Place: ❒ Office ❒ Emergency Room

Treatment given to patient:

Mention the names of doctors that evaluated the patient or referred for this condition or another related condition:
(PLEASE INDICATE THE PATIENT TO INCLUDE THE ADDRESSES AND PHONE NUMBER OF THESE DOCTORS)

NAME	SPECIALTY	DIAGNOSTIC	DATE(m, d, y)

Have the patient had the same or similar injury before? ❒ Yes ❒ No
If you answered affirmative, mention date: M____ D____ Y____ Describe: _____

Indicate the disability period of the patient: From: M_____ D_____ Y_____ To: M_____ D_____ Y_____

Describe any other acute or chronic condition that the patient suffered before and mention the date that each one was diagnosed:

DIAGNOSTIC	DATE STARTED (m, d, y)

Have the patient had any surgery? ❒ Yes ❒ No Date: M_____ D_____ Y_____ **(Please enclosed surgery report)**

If there was dismemberment, indicate extremity and localization: _____ Date: M__D__Y__

In a case of vision loss from one or two eyes, if this a total and irrecoverable loss? ❒ Yes ❒ No
Explain and mention grade: _____

Have the patient been hospitalized or had outpatient treatment due to any sickness or injury? ❒ Yes ❒ No
If you answered affirmative, indicate hospital name, sickness and period hospitalized:

HOSPITAL	DIAGNOSTIC	PERIOD (m, d, y)
		From: _____ to _____
		From: _____ to _____

Additional Information _____

_____ Doctors Signature

_____ Print Name

_____ Specialty

_____ License No.

_____ Date

_____ Postal Address

_____ Phone Number

HOSPITAL CERTIFICATION

Patient Name	Age	Sex ❒ M ❒ F
Address	SS# / /	

Dx: _____ Type of Service: Hospitalized _____ Outpatient _____

Name of the doctor that hospitalized you _____ License No. _____

Period hospitalized in a regular room: M____D____Y____ Time: _____ am/pm To M____D____Y____ Time: _____ am/pm

Intensive Care unit: (Type of Unit) _____ Dx: _____

From: M____D____Y____ Time: _____ ❒ a.m. ❒ p.m. To: M____D____Y____ Time: _____ ❒ a.m. ❒ p.m.

Indicate previous admissions:	From: M____D____ Y____ To M____D____ Y____ From: M____D____ Y____ To M____D____ Y____	Dx: _____ Dx: _____
Hospital Name		Record No.

Authorized signature _____ Title: Medical Records Room
Name in printing _____ Date: M_____D_____Y_____

IMPORTANTE ADVICE: In case that the Hospital does not complete this certification, we will accept copy of the admission or discharge summary, the certification of Intensive Care Unit or the progress notes.

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