TRIPLE-S VIDA

INVOLUNTARY UNEMPLOYMENT BENEFITS CLAIM FORM

PART I	INSURED DECLARATION		
NAME (last name, second name, name)			Policy Num.
Date of Birth Month _____ Day _____ Year _____	Social Security / /	E-mail	Telephone
Postal Address: P.O. BOX	Num. / Avenue / Street	City	Country Zip code
Residential address	Num. / Avenue / Street	City	Country Zip code
Name and address of the employer (which you were working at the time of losing your job)			Telephone
Name and position of your immediate supervisor		Dates you were unemployed (month, day, year) From _____ /____ /____ Until _____ /____ /____	
Explain the causes why you became unemployed. (You have to be unemployed during 31 consecutive days and employed by the same Employer during the 12 months preceding the date of loss of employment as a regular employee working 30 hours a week, at least.)			
Are you eligible to receive Unemployment Benefits? ❒ Yes ❒ No		Are you receiving Unemployment Benefits for the period claimed? ❒ Yes ❒ No	
If you are not eligible to receive Unemployment Benefits, explain. (If you have registered in a State or local employment agency, include a copy of the card)			
Are you unemployed at this time? ❒ Yes ❒ No		If your answer is no, when you returned to work? Month_____ Day _____ Year _____	
Type of Employment: ❒ Regular full-time employee (minimum 30 hrs. Per week) ❒ Temporary employee contract		❒ Independent Contractor ❒ Self employed	
Are you employed by an Employer who is your: ❒ spouse ❒ father ❒ mother ❒ son/daughter ❒ brother/sister		Were you a shareholder of your employer? ❒ Yes ❒ No Percentage of shareholder _____%.	

NOTICE

"Any person who knowingly presents false information on an insurance application with the intention of committing fraud, or, who, presents, or helps presents, a fraudulent claim for the payment of a loss of 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". Law 230 of august 9, 2008.

I CERTIFY THAT THE INFORMATION PROVIDED IN THIS FORM IS COMPLETELY TRUE.

_____ Claimant 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.
PO BOX 363786 • SAN JUAN PR 00936-3786 • Tel. (787) 758-4888
www.sssvida.com

PART II	EMPLOYER CERTIFICATION		
Name of the Claimant:			Social Security / /
Name of the Employer:		Telephone:	E-mail:
Address: P.O. BOX	Num. / Avenue / Street	City	Country / Zip code
Date of employment: Month_____ Day _____Year _____	Date of termination: Month_____ Day _____Year _____	Date of notification of the termination (oral or written): Month_____ Day _____Year _____	
Type of Employment: ❒ Regular full-time employee (minimum 30 hrs. Per week) ❒Temporary employee contract		❒ Independent Contractor ❒ Self employed	
Causes for termination:			
Corporate Seal	I certified that the information provided by me in this form is true. _____ Name of the Authorized Officer _____ _____ Signature of the authorized Officer Date		

Instructions:

- **Complete the Insured Declaration and the Employer Certification**
- **Please, attach the termination letter, a copy of the check stub indicating the amount of hour worked and the letter from División de Seguro por Desempleo which state your eligibility. In addition, attached copy of your unemployment record or check stubs. This information is required for each month in which you have remained continuously unemployed. The dates of the check stubs or the dates of the unemployment record must correspond to the same dates on which you are requesting unemployment benefits.**
- **Return this claim form to Triple-S Vida, Inc. If this claim form is not fully completed, the claim form will be returned to your postal address and your claim will not be processed.**

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