TRIPLE-S VIDA

CLAIM FORM

CANCER POLICY, SICKNESS AND INTENSIVE CARE

Policy No.

Insured Name	Social Security
Patient Name	Social Security
Postal Address	
Residential Address	

Relationship	Sex: ❒ M ❒ F	Patient Date of Birth (m, d, y)	Phone No.	E-mail

CLAIMANT INFORMATION

1. Diagnostic, what condition was diagnosed?

2. When was the first symptom of your condition?
   Date (m, d, y): _____

3. When was your first doctor's visit for this condition?
   Date (m, d, y): _____

4. 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	DATE OF SERVICE	DIAGNOSTIC	POSTAL ADDRESS	PHONE NUMBER

5. Have you been hospitalized during the past three years?

HOSPITAL NAME	HOSPITALIZATION PERIOD	DIAGNOSTIC

6. Please indicate your actual occupation and last date of work. _____ Date (m, d, y) _____

7. If your dependent child under 21 years old is the claimant, please include Student Certification.

8. 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 No. 230 dated August 9th, 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.

HOSPITAL CERTIFICATION

Patient Name	Age	Sex: ❒ M ❒ F
Address	Social Security	
Dx: _____	Type of Service: ❒ Hospitalized ❒ Outpatient	
Name of the doctor that hospitalized the patient	License No.	

Period hospitalized in a regular room:
From: 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: _____ ❒ am / ❒ pm **To:** M____D____ Y____ Time: _____ ❒ am / ❒ pm

Indicate previous admissions:	
From M____D____ Y____ To M____D____ Y____ Dx: _____	From M____D____ Y____ To M____D____ Y____ Dx: _____

Hospital Name	Record No.
Authorized signature	Title: Medical Records room
Name in printing	Date (m, d, y)

IMPORTANT NOTICE: 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.

TRIPLE-S VIDA, INC.
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MEDICAL STATEMENT

Patient Name:	Age:
Diagnostic:	Date of first medical visit (m, d, y):
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 a similar condition before? ❒ Yes ❒ No If you answered affirmative, mention date (m, d, y): _____ Describe and indicate if there were any exams, biopsies, laboratories, etc.:

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)**

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

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

Additional Information _____

_____ Doctors Signature

_____ Print Name

Specialty	License No.	Date (m, d, y)
Postal Address		Phone Number

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