TRIPLE-S VIDA

APPLICATION FOR POLICY REINSTATEMENT

Insured:	Policy No.:	
Mailing Address Urb. , PO Box, HC, RR Number / Street City Country Zip Code	Telephone ( )	Social Security No. / /
E-mail:		

TYPE OF INSURANCE

❒ **Life Insurance**	❒ **Universal Life Insurance**	❒ **Other:**_____
❒ **Disability Income**	❒ **Cancer**	_____

The statements made below apply to EACH PERSON that would be insured under this policy, if reinstated. The **INSURED, OTHER INSURED PERSONS** and **THE INSURED'S CHILDREN**, if applicable, and to the **PAYER**, if a Payer benefit is featured.

IMPORTANT: To apply for reinstatement**, QUESTIONS, 1, 2, 3, 4 MUST BE ANSWERED FOR ALL TYPES OF POLICIES AND DETAILS MUST BE PROVIDED ON ALL AFFIRMATIVE REPLIES.**
To the best of your knowledge:

1. In the last five years (or the period since the policy date, whichever is shorter) have any of the people who would be insured in this policy (including the Payer, if you are requesting reinstatement of said benefit), if reinstated:

	Primary Insured		Other / Spouse		Children	
	Yes	No	Yes	No	Yes	No
A. Been denied, postponed or been charged an additional premium for life insurance, universal life insurance, disability income or cancer insurance, or been offered a policy different to that which was applied for, or been denied reinstatement or renewal of said insurance? (If you answer "YES", please explain)……						
B. Been in a hospital, clinic or institution for examination, observation, diagnosis, operation or treatment; or has been treated or examined by other physicians or healthcare professionals?……....						
2. At the present time, is any person covered under this policy receiving treatment for any abnormality, deformity, illness or disorder?……..						
3. Has any person covered under this policy applied for or currently receives disability benefits from any other source?…….....						
4. During the past ten years (or the period since the policy date, whichever is shorter):						
A. Has undergone any medical examinations, laboratory tests or other medical consultations that were not previously mentioned?……..						
B. Has been diagnosed with or has undergone treatment for the Acquired Immunodeficiency Syndrome (AIDS) or the AIDS-Related Complex (ARC)? ……..						
C. Suffers from or has suffered from or has had one or more of the following symptoms? 1) unexplained weight loss. ……..						
2) unexplained fever; ……..						
3) persistent coughing not related to smoking or colds; ……..						
4) night sweats; ……..						
5) skin, mouth or rectum lesions;……..						
6) swelling of the Lymph Nodes; or ……..						
7) unexplained diarrhea ……..						

WRITE HERE THE DETAILS of the **AFFIRMATIVE** replies for questions 1, 2, 3, 4. Please state the names of the persons, illness or lesion, dates, treatment results, names and addresses of each physician and hospital. (Use the back of the form if you need more room).

_____

_____

5. Have you used tobacco products in the last 36 months? ❒ YES ❒ NO In the last 12 months? ❒ YES ❒ NO
   Form of tobacco: ❒ Cigarettes ❒ Pipe ❒ Cigars ❒ Other:_____

6. Has any additional insured used tobacco products in the last 36 months? ❒ YES ❒ NO ¿In the last 12 months? ❒ YES ❒ NO
   Form of tobacco: ❒ Cigarettes ❒ Pipe ❒ Cigars ❒ Other:_____

IF YOU ARE APPLYING FOR A POLICY REINSTATEMENT OR DISABILITY INCOME BENEFIT, ALSO FILL OUT THE FOLLOWING

7. A. Is the insured actively working and on a full-time basis? ❒ YES ❒ NO
   B. Occupation _____ Duties _____ Annual Income $ _____
   C. At the present time, are you receiving disability income from any source? ❒ YES ❒ NO. If you are receiving disability income, please state the source: _____
   D. If the person named as the insured becomes disabled, please state the total disability income amount payable each month from all other sources **except this policy.**

All Individual Insurance policies ……....	❒ None or $_____ Monthly
All Group Insurance policies……..	❒ None or $_____ Monthly
All others……	❒ None or $_____ Monthly

CONFIDENTIALITY NOTICE

Personal information can be obtained from other persons in addition to you. This information, subsequently obtained by us or by our agent, may in some circumstances be revealed to third parties without authorization. You have the right to have access to and to make corrections regarding all obtained personal information. At your request, you will be provided with a detailed notice regarding information use.

TRIPLE-S VIDA, INC.
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www.sssvida.com

Public Law 91-508

As part of our procedure to evaluate your insurance application, a consumer investigation report may be prepared, in which information will be obtained through personal interviews with your neighbors, friends and other persons to whom you are connected. This investigation includes information on your character, general reputation, personal characteristics and lifestyle. You have the right to request, in writing and within a reasonable period of time, to receive additional and detailed information about the nature and scope of this investigation.

IMPORTANT NOTICE

It is agreed that this policy will not be reinstated and that we will bear no responsibility (only for returning payments made consequently by this application, without interests) until: 1) all the money required to reinstate this policy has been paid; and 2) this application has been approved by us at our Headquarters during the lifetime of all the people who would be insured in this policy, if reinstated. It is agreed that the reinstatement date will be as follows: 1) the date in which we approve the reinstatement application on all life insurances (other than universal life), disability income insurance and cancer insurance; or 2) the first day of the monthly anniversary on or after the date we approve the application for reinstatement on universal life insurance. In addition, it is agreed that reinstatement of this policy, if awarded, will be contested in case of fraud or due to erroneous statements of any material fact established in, or relating to, this application, **for two years after the Reinstatement Date**. In the case of a life insurance policy (other than universal life insurance), all due premiums must be paid. In the case of a universal life policy, the minimum premium deficiency must be paid until the reinstatement date, if approved, plus a minimum of premiums that is enough to maintain the policy in effect for two months. In the case of a disability income or cancer policy, any accepted premium linked to a reinstatement will be applied to a period for which no prior premiums have been paid, but never for a period greater than 60 days prior to the reinstatement date.

The risk evaluation and classification process is necessary to insure and provide a mechanism through which the Owners of the policy will pay the cost. When your application is evaluated, information from various sources is taken into consideration, including your statements, the results of your physical exam (if required), and any report we get from physicians or medical institutions in which you have received care.

The information regarding your insurability will remain confidential. We, or our reinsurers, nevertheless, can prepare a brief report on the matter for the Medical Information Bureau (MIB), a non-profit organization that operates as an information clearinghouse. If you apply for life insurance or health insurance coverage from another company affiliated to the Bureau, or submit a claim for benefits to said company, the Bureau, upon request, will provide said company with the information it has on file.

Upon receiving your request, the Bureau will reveal any information it has on its files (medical information will only be revealed to your physician). If you have doubts regarding the accuracy of the information on file at the Bureau, you may contact them and make corrections according to the procedures explained in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: Post Office Box 105, Essex Station, Boston, MA 02112, and their telephone number is (617) 426-3660. We, or our reinsurers, can also reveal information on our files to other life insurance companies to which you submitted a claim.

"**You**" and "**your**" means the owner of the policy and the insured, if different from the owner, and the other insureds. "**We**", "**Us**" and "**Our**" means **Triple-S Vida, Inc.**, San Juan, Puerto Rico.

Statements made above are true to the best of my knowledge and understanding. All persons applying for reinstatement adopt, as theirs, said statements.

Law 230 August 9, 2009

Any person who knowingly and with the intent to commit fraud submits false information on an insurance application will incur in a felony and if convicted will be sanctioned, for each violation, with a fine of no less than five thousand (5,000) dollars and no more than ten thousand (10,000) dollars or incarceration for a fixed term of three (3) years, or both. If aggravating circumstances are present, the established fixed incarceration period may be increased up to a maximum of five (5) years; if there are mitigating circumstances, it may be reduced to a minimum of two (2) years.

AUTHORIZATION

Through this form I hereby authorize any: 1) licensed physician; 2) medical practitioner; 3) clinic; 4) hospital or any other medicine-related or medical institution; 5) insurance company; 6) the Medical Information Bureau (MIB); 7) any other person, organization or institution that may have any file or knowledge about me (us) or my (our) health, to provide **Triple-S Vida, Inc.**, or its reinsurers, with any information and to testify regarding said information, to the extent permissible by law. I understand that the information obtained from this form will be used by **Triple-S Vida, Inc.,** or by its reinsurers, to determine my (our) eligibility for insurance. I may request a photocopy of this authorization. This form will be valid for two years and six months from the date stated below.

_____	_____	_____
Policy Owner's signature (mandatory)	Date	Witness
_____	_____	_____
Insured's signature, if different from the Owner of the Policy, or one parent, if the Insured is an underage child.	Date	Witness
_____		
Additional Insured's signature		

FOR HEADQUARTERS OFFICE USE

MANAGER'S REPORT (if this is an M.D.O. policy)

Debit No. _____ Page No._____ Plan_____ Premium $_____ Date _____

AMOUNT DEPOSITED WITH THE REINSTATEMENT APPLICATION: $ _____

Manager's signature _____ District _____