TRIPLE-S VIDA
PO Box 363786
San Juan PR 00936-3786

WAIVER OF PREMIUM CLAIM FORM

Claimant's Statement

Section 1: To be completed by employee

Please complete the entire claim form. Verification will be made upon receipt of the completed form. This form cannot be processed if information is incomplete. Please print clearly using black or blue ink.

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, and be reduced to a minimum of two (2) years." Law No. 18 dated January 8th, 2004.

1	Name:			2 Social Security No:
	Address:			3 Phone No: ( )
	City, Zip Code:			4 Date of Birth:
5	Height:	6 Weight:	7 Gender: ☐ M ☐ F	8 Employer's name:
11	Date of accident or date of first symptoms?	12 Last day worked		13 Are you unable to work due to: (check one) ☐ Injury ☐ Illness

16 Describe in details, when, where and how accident occurred, or nature of disablity and first symptoms

19	When were you treated for your illness or accident?		
	Hospital	Address	Dates
	Doctor	Address	Dates
20	Have you ever had same or similar condition in the past? ☐ Yes ☐ No	If yes, list name and address of Hospital or Doctor below:	
	Hospital	Address	Dates
	Doctor	Address	Dates
	Name of medical insurance carrier	Address	

I certify that the statements made herein are according to our knowledge and understanding true. (Your signature is required)

Signature **X** _____ Date _____

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Employer's Statement

Section 2: To be completed by employer

Please complete the entire claim form. Verification will be made upon receipt of the completed form. This form cannot be processed if information is incomplete. Please print clearly using black or blue ink.

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1	Employee's Name		2 Social Security No:
	Address/Box/Apt.		3 Date of birth
	City, State, Zip code		4 Last day worked:
5	Date of hired:	6 Employee's Group Life Insurance Effective date:	7 Occupation:
8	Policy No:	9 Amount of Life Insurance:	10 Policy Class:
11	Is employee still working: /__/ Yes /__/ No	Reason:	
12	Do you expect your employee to return to work?		
13	Salary prior to date last worked		
14	Name and Address of the employee's medical insurance carrier or HMO (provide policy or ID No.)		

I certify that the previous declarations are, in accordance with our knowledge and to understand, true.

15	Employer's name:		Phone No ( )	
	Address	City	State	Zip code
	Signature (No Stamp) **X**	Occupation		Date

TRIPLE-S VIDA

Physician's Statement

PO Box 363786
San Juan PR 00936-3786

Section 3: To be completed by attending physician

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Patient Name		Date of Birth	Social Security No:
Height	Weight	Blood Pressure (last visit)	

1 Patient is/was unable to work due to: (check one) ☐ Injury ☐ Illness

2 Diagnosis (include complications and ICD 9)

3 When did symptoms first appear or accident happen?	4 Date you advised patient to stop working

5 Has patient ever had same or similar condition? ☐ Yes ☐ No	If yes, state when and describe

6 Date of first visit	7 Date of last visit	8 Frequency of visits

9 Objective Findings(X-rays, EKG's, lab data and clinical findings)	10 Subjective Symptoms

11 Nature of Treatment (surgery, medications, etc.) Provide medication dosage and frequency

12 Names and address of other physicians:

13 Has patient been hospitalized? ☐ Yes ☐ No If yes, give name and address of hospital

From _____ To _____

14 Progress a. Is the patient (choose one): ☐ Recuperated ☐ Better ☐ Not changed ☐ Worsen b. Is the patient (choose one): ☐ Ambulating ☐ Bed ridden ☐ House confined	15 Prognosis (Please be specific)

16 Remarks:

17 If this is a cardiac condition, what is the functional capacity? (American Heart Association) ☐ Class 1 - No Limitation ☐ Class 2 – Slight Limitation ☐ Class 3 – Marked Limitation ☐ Class 4 – Complete Limitation

18 Has maximum medical improvement been achieved? ☐ Yes ☐ No If no, when do you expect a fundamental change? ☐ 1-2 weeks ☐ 3-4 weeks ☐ 5-6 weeks ☐ More than 6 weeks

19 Physician's Name (Please Print)			Degree
Specialty		Phone No.	Fax No.
Address	City	State	Zip code
Signature (No Stamp) **X**		Tax Id No.	Date