TRIPLE-S VIDA

PROOFS OF DEATH
CLAIMANTS STATEMENT

1. Name of Insured		Date of birth	Social Security
Date of death	Place of death		Cause of death

2. Policies of this Company under which claim is being made by the undersigned.

Policy Number	Amount of Death Benefit Claimed	Accidental Death Benefit Claimed
	$	$
	$	$
	$	$

3. Beneficiary Information

Name	Social Security	Date of Birth

Relationship to the deceased.	Phone Num.:	Cell Phone	E-mail

Postal Address:

Residential Address

4. Have you visited other doctors during the past two years? ❒ Yes ❒ No
If you answered affirmative, please indicate the names, address and telephone number.

Name: _____	Name _____
Address: _____	Address: _____
Date: _____	Date: _____
Telephone number: _____	Telephone number: _____

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

HOSPITAL NAME	ADDRESS	DIAGNOSTIC

I hereby certify that I am the claimer under these Proof of Death, that the statement above are true and complete and that the above named deceased is the person insured under the policies enumerated above. I further agree that the furnishing of claim form by the Company shall not be considered an admission by the Company that there was any insurance in force on the deceased or a waiver of any of the Company's rights or defenses.

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: _____

Witness: _____ Address: _____

DO YOU WANT TO RECEIVE FAST AND SECURE PAYMENTS?

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 • Fax: (787) 758-7826
www.sssvida.com

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	

CL-0404-110 (R-0517)

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