

## 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 than 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.

- 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.

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: <input type="checkbox"/> Check <input type="checkbox"/> Savings	E-mail
Authorized Signature	Authorization Date	<input type="checkbox"/> I authorize Triple-S Vida, Inc., to send the payment notice to my email.

## 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: <b>(PLEASE INDICATE THE PATIENT TO INCLUDE THE ADDRESSES AND PHONE NUMBER OF THESE DOCTORS)</b>			
NAME	SPECIALTY	DIAGNOSTIC	DATE(m, d, y)
Have the patient had the same or a similar condition before? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: M____ D____ Y____ <b>(Please enclosed surgery report)</b>			
Have the patient been hospitalized or had outpatient treatment due to any sickness? <input type="checkbox"/> Yes <input type="checkbox"/> 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-1018)