TRIPLE-S VIDA

CLAIM FORM

CANCER POLICY, SICKNESS AND INTENSIVE CARE

				Policy No.
Insured Name				Social Security
Patient Name				Social Security
Relationship	Sex ❒ M ❒ F	Patient Date of Birth (m, d, y)	Phone No.	E-Mail
Postal Address				
Residential Address				

PATIENT 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 two 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 two 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

IMPORTANT NOTICE: "Any person who knowingly presents false information on an insurance application with the intention of committing fraud, or, who, presents, or helps presents, a fraudulent claim for the payment of a loss of other benefit, or presents more than one claim due to the same loss or damage, commits a severe offense and will be sanctioned for each offense with a penalty of not less than five thousand dollars ($5,000), and not more than ten thousand dollars ($10,000) or penalty of imprisonment for a term of three (3) years, or both penalties. If aggravating circumstances exist, the imprisonment penalty could be increased up to a maximum of five (5) years; if extenuating circumstances exist, the imprisonment penalty could 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

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.
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www.sssvida.com

T R I P L E - S V I D A , I N C .
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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 (Include Stamp of the Institution)	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.

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	