TRIPLE-S VIDA

DEATH CLAIM FORM
(ILLNESS OR ACCIDENTAL)

CLAIMANT DECLARATION

1. Insured's name				Date of Birth			
Last Name	*Second last Name*	*Name*	*Inicial*	Day	Month	Year	Social Security

2. Indicate the policy under which you are claiming

Policy Number	Life Insured Amount	Accidental Insured Amount
a)	$	$
b)	$	$
c)	$	$

3. Beneficiary's name				Date of Birth			Social Security
Last Name	*Second last Name*	*Name*	*Inicial*	Day	Month	Year	Phone:
Postal Address:							E-mail:
Urb. PO Box, HC, RR, Neighborhood	Núm./ Street	City	Country	Zip code			

4. Indicate your relationship with the Insured: _____

5. Was the Benefit of this policy assigned to a funeral home? ☐ YES ☐ No Funeral Home name: _____

IMPORTANT NOTICE: In a claim whose policy effective date is less than two (2) years, you must submit the **Death Certificate model RD-77 Rev. 01/89.** In a claim where the insured died outside of Puerto Rico, please submit the Discharge Summary from the hospital where the insured died. For other documents, see the reverse.

INSURED INFORMATION

1. Cause of death : _____ 2. Date of Death: Month: _____ Day: ____ Year: _____

3. Indicate the names and medical specialties of the physicians that the insured visited during the last three (3) years.

a) **Name:**	Specialty:	Date of the Service:
Postal Address:	Phone:	Diagnosis:
Urb, PO Box, HC, RR Num./Street City Country Zip code		
b) **Name:**	Specialty:	Date of the Service:
Postal Address:	Phone:	Diagnosis:
Urb, PO Box, HC, RR Num./Street City Country Zip code		

4. Indicate the names of the hospitals and/or treatment center that the insured visited during the last three (3) years.

Hospital's name and address	Date of the hospitalization	Diagnosis:

APLIES FOR THE CANCER POLICY ONLY:
5. If the claimant is a dependent child over 21 years of age, please include the Student Certification.

6. Civil status of the dependent child: ☐ Married ☐ Single ☐ Divorced

I certify that I am the claimant on this proof of death declaration. The above provided information is true and complete. The person described is insured under the enumerated policies in box number two (2). I agree that all files and/or declarations submitted by the physicians, hospitals, diagnostics centers, or institutions regarding the insured and all other pertinent documentation will be considered as part of the proof of death. I understand that when Triple-S Vida, Inc. provides claim forms, this action cannot be considered an admission that the insurance was inforce; providing claim forms does not constitute a waiver of the Company's rights or defenses. **NOTICE** "Any person who knowingly and with intent to commit fraud submits false information in an application for insurance or who submits, assists or files a fraudulent claim for the payment of a loss or other benefit, or files more than one claim for the same damage or loss, shall incur in a felony and if convicted, each violation will carry a fine of no less than five thousand (5,000) dollars and no more than ten thousand (10,000) dollars or imprisonment for a fixed term of three (3) years, or both penalties. If there are aggravating circumstances, the established fixed penalty may be increased up to a maximum of five (5) years; if there are extenuating circumstances, it may be reduced to a minimum of two (2) years." Act No. 230 of August 9, 2008.

☐ I request a check as the only payment method. I am canceling any previous authorization for a direct deposit to my account.

☐ I am notifying you that my bank account number has changed.

Beneficiary's signature: _____ Date _____

Witness: _____ Date _____
(Witness of the mark)

Signature: _____ Debit _____
Manager, Supervisor or Authorized Representative

SEE THE REVERSE SIDE

TRIPLE-S VIDA, INC.
PO BOX 363786 ♦ SAN JUAN PR 00936-3786 ♦ Tel. (787) 758-4888 ♦
reclamacionesindividual@sssvida.com

Authorization for electronic payment method of insurance policy benefits to claimants

I authorized Triple-S Vida to make electronic deposits to my personal bank account in the amount of the benefits claimed regarding my insurance policies or the insurance policies in which I am a beneficiary. I understand that for any change of bank account or any order to revoke this authorization I must submit my request in writing thirty (30) days in advance. Enclosed you will find a void check or any other official evidence. In my bank account ☐ Check ☐ Savings

Name of the bank	Num route and transit	Num bank account
Name of the bank account owner	Signature of the bank account owner	E-mail
Authorized signature	Authorization date	☐ I authorize Triple-S Vida, Inc. to send the payment deposit notice to my email

IMPORTANT NOTICE: THE TREATING PHYSICIAN'S REPORT MUST BE COMPLETED IF THE CLAIM IS SUBMITTED UNDER A POLICY WITH LESS THAN TWO YEARS INFORCE.

TREATING PHYSICIAN'S REPORT

1. Name of the patient: | Age

2. Diagnosis: | Date of the first symptoms: M_____ D_____ Y_____

3. Date of the Accident, (if apply) (M) _____ (D) _____ (Y) _____ | If there was a fracture, was it confirmed with X-rays? ❒ Yes ❒ No

4. In case of an accident, where did you receive the first treatment? _____

5. **Indicate the name of the doctor(s) who treated or referred the patient for an illness that affected the cause of death: (PLEASE INSTRUCT THE BENEFICIARY TO INCLUDE THE ADDRESSES AND TELEPHONE NUMBER OF THESE PHYSICIANS)**

NAME	MEDICAL SPECIALIST	ILLNESS OR INJURY

6. Did the patient have this illness or a similar illness? ❒ Yes ❒ No

If answered Yes, indicate when: (M) _____ (D) _____ (Y) _____
Describe: _____

7. Describe any chronic or acute illness the patient underwent.

Illness	Onset Date of the Illness

8. Describe any other illness or infirmity that affected the cause of death. _____

9. Had the patient has any surgery? ❒ Yes ❒ No Date (M) _____ (D) _____ (Y) _____ (**Please, include surgery report)**

10. Was the patient hospitalized or received outpatient treatment for any illness or injury? ❒ Yes ❒ No

If yes, please provide name and address of the hospital, name of illness or injury, and dates of confinement:

HOSPITAL	ILLNESS OR INJURY	DATES
		From: (M) _____ (D) _____ (Y) _____ To : (M) _____ (D) _____ (Y) _____
		From: (M) _____ (D) _____ (Y) _____ To: (M) _____ (D) _____ (Y) _____

11. Additional Information: _____

12. Certification and signature:
I certify that the above information, in my opinion, truly describes the patient's condition and the approximate duration of the medical condition. I am a licensed practicing physician.

Name	Medical Specialist	License num.
Address		Phone:
Neighborhood / Urb / RR / HC / P0 BOX — Núm. / Ave/ Street — City — Country — Zip code		
Signature:	Date:	