TRIPLE-S VIDA

APPLICATION FOR CHANGE OF BENEFICIARY

Instructions and Guidelines

A. The insured is the owner of the policy unless otherwise stated on the insurance application or on a rider.

B. If the insured is a minor, then the policy owner is the applicant.

C. A change of beneficiary under the policy can only be requested by the insured person; if he/she is not the owner of the policy, then by the owner.

D. If the insured or the owner of the policy is an individual who is unable to read and write, then he/she shall write a mark and a witness who is not the beneficiary being designated herein will sign the form.

E. An application for change of beneficiary submitted to or received by an agent **IS NOT** considered a change submitted to the company.

F. You do not have to submit your policy for a change of beneficiary to be processed.

G. When completing the application for change of beneficiary you must verify that all information requested has been disclosed and that you have signed in the space provided for this purpose.

H. You should receive the processed change of beneficiary or a letter informing you if any information is missing in the document within 60 days after submitting your application at our office. If you do not receive the change of beneficiary or a letter within the period stated herein you must contact TSV's headquarters by calling **787-758-4888**.

I. Triple-S Vida, Inc., may require that this form be signed in presence of a District Office Official, Manager or Secretary or in presence of a Customer Service Representative or signed in presence of a Notary Public.

Attorney in fact who is signing the application in capacity as Power of Attorney or Durable Power of Attorney, must submit certified copy of the Power of Attorney deed granted to him/her; evidence that the said deed was duly registered at the *Registro de Poderes y Testamentos* office; evidence that the Power of Attorney has not been withdraw. The Power of Attorney or Durable Power of Attorney deed should express that the Attorney in Fact has been granted authorization to request change of beneficiary in life or disability insurance policy.

In case minors are designated as beneficiaries; according to law, our company must consign policy benefit payments at the Court of First Instance in case the beneficiary is a minor at time of payment. The Court will determine if it will retain the money until the beneficiary becomes of legal age, if part of the money will be given to the minor's Legal Guardian or if any other measure deemed fit will be taken. All our liability as an insurer will end once our company consigns a policy benefit payment at the Court of First Instance.

Notice any person who, knowingly and with the intent to commit fraud, provides false information in an insurance application, or provides, helps in providing or assists in the transmittal of a fraudulent claim for payment of loss, or any related benefit, or files multiple claims for the same loss or benefit, will incur in a felony, whereupon, if convicted, will be sanctioned with an economic fine of no less than five thousand dollars ($5,000) but no more than ten thousand dollars ($10,000) per violation, or incarceration for a mandatory term of three (3) years, or both. In case of aggravating circumstances, this term could be extended to a maximum of five (5) years; and in case of mitigating circumstances, it could be reduced to two (2) years.

TRIPLE-S VIDA

APPLICATION FOR CHANGE OF BENEFICIARY

PART I	INSURED INFORMATION			
Insured's Name				❒ PRIMARY INSURED ❒ ADDITIONAL INSURED
Mailing Address (Urb./PO Box, HC, RR, Calle, Número)	City	State	Zip Code	Home Phone ( )
E-mail				Cel. Phone ( )

PART II	INSURANCE CONTRACT INFORMATION		
Policy Number	Social Security Number	Did you assign this insurance policy? ☐ YES ☐ NO	Assignee Name
Policy Number	Social Security Number	Did you assign this insurance policy? ☐ YES ☐ NO	Assignee Name
Policy Number	Social Security Number	Did you assign this insurance policy? ☐ YES ☐ NO	Assignee Name
Policy Number	Social Security Number	Did you assign this insurance policy? ☐ YES ☐ NO	Assignee Name

PARTE III BENEFICIARY DESIGNATION

I AUTHORIZE Triple-S Vida, Inc., from now on TSV, to make the following change in the abovementioned policy contract. **I CERTIFY** that the insurance contract for which I request changes have not been assigned to a natural or legal person, except as it is explained above, nor is it being used to guarantee a loan or any type of debt. In addition, no banckruptcy action has been initiated against me. **ONCE THE CHANGE IS APPROVED** it will be effective on the date this application was signed, subject to the policy's terms and conditions, if received and registered at TSV's headquarters while the insured is alive. Once the beneficiary change has been received and registered at the insurer's headquarters, this application will become part of the policy contract. **BY VIRTUE** of the rights conferred to me under the terms of the insurance contract issued to the individual stated above as the insured and identified by the corresponding policy number, **I HEREBY** cancel any prior beneficiary designation and/or selection of Non-Forfeiture Benefits. I request to TSV the designation of beneficiary be registered as indicated below.

PRIMARY BENEFICIARY

Names Initial Surnames	Barth Date	Identification Num.	Relationship	Percent of Benefit
Adress (Urb./PO Box, HC, RR, Number, Street)	City	Country	Zip Code	Phone number
E-mail:				
Names Initial Surnames	Birth Date	Identification Num.	Relationship	Percent of Benefit
Adress (Urb./PO Box, HC, RR, Number, Street)	City	Country	Zip Code	Phone number
E-mail:				
Names Initial Surnames	Birth Date	Identification Num.	Relationship	Percent of Benefit
Adress (Urb./PO Box, HC, RR, Number, Street)	City	Country	Zip Code	Phone number
E-mail:				
Names Initial Surnames	Birth Date	Identification Num.	Relationship	Percent of Benefit
Adress (Urb./PO Box, HC, RR, Number, Street)	City	Country	Zip Code	Phone number
E-mail:				

CONTINGENT BENEFICIARY

Names Initial Surnames	Birth Date	Identification Num.	Relationship	Percent of Benefit
Adress (Urb./PO Box, HC, RR, Number, Street)	City	Country	Zip Code	Phone number
E-mail:				
Names Initial Surnames	Birth Date	Identification Num.	Relationship	Percent of Benefit
Adress (Urb./PO Box, HC, RR, Number, Street)	City	Country	Zip Code	Phone number
E-mail:				

I agree to hold Triple-S Vida, Inc., harmless from all losses, liabilities, damages, costs, expenses, attorney fees incurred as a result of any claim or suit which result from the requested change.

_____ _____
Primary Insured or Owner signature or Irrevocable Beneficiary — Date (Day/Month/Year)

_____ _____ _____
Name and Signature of the Witness — Date (Day/Month/Year) — Witness' Identification Number

SWORN STATEMENT – IF IT IS REQUESTED BY THE COMPANY

AFFIDAVIT NUM. _____

Sworn and sign in my presence by _____, of legal age, _____ (civil status),

_____ (occupation) and resident of _____ (city and state); whom I identified

by means of _____At _____(city and state), on _____(month) ____ (day) _____ (year).

_____ NOTARY

EXCLUSIVE USE OF THE COMPANY

Debit or Service Representative Num. _____
Representative who received requested change _____
Official, Manager or District Representative
District Office _____Date: _____

Home Office Approval Seal and
Service Representative's signature who approved the requested change