TRIPLE-S VIDA

DISABILITY BENEFITS REQUEST FORM

PLEASE PRINT YOUR ANSWERS

PART 1	CLAIMANT'S STATEMENT	
1. Name		2. Date
3. Mailing Address		
4. Residential Address		
5. Telephone No.	6. Cellphone No.	7. Email
8. Policy Number	9. Effective Date	10. Last Payment (Date)
11. Occupation	12. Social Security No.	13. Monthly Wages
14. Tasks you do at work:		
15. First day you were disabled and unable to work: Month _____ Day _____ Year _____		16. Date you returned to work or date when you expect to go back to work: Month _____ Day _____ Year _____

17. Your disability is related to:

❒ Performing your job ❒ Car accident ❒ Pregnancy or abortion ❒ Another reason:

Specify where, when and how it happened: _____

_____

_____

_____

18. If your case was reported to the State Insurance Fund, please write the case number: _____

Have you ever applied for benefits from Social Security, the State Insurance Fund or any other public or private plan that provides disability? ❒ Yes ❒ No

From: Month___ Day ___ Year____ To: Month___ Day___ Year____.

19. Are you, or were you hospitalized? ❒ Yes ❒ No If "yes", specify: _____

Hospital Name	Hospitalization Date:	Diagnosis:	Record Number:
1. _____	Month _____ Day ____ Year _____	_____	_____
2. _____	Month _____ Day ____ Year _____	_____	_____

IMPORTANT NOTICE

Any person who knowingly and with the 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**.

_____ _____

Signature Date

DO YOU WANT TO RECEIVE YOUR BENEFITS PAYMENT IN A FAST AND SECURE FASHION?

❒ 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.

Authorization to Issue Electronic Benefit Payments to Claimants

I authorize Triple-S Vida to enter deposits in my personal bank account to pay for claimed benefits associated with the Triple-S Vida policy (policies) that I own or in which I appear as a beneficiary. I understand that any account changes or any particular order to revoke this authorization must be submitted in writing, thirty (30) days in advance. Please include a copy of a canceled check or any other official evidence.

_____ Bank name and Branch

_____ Routing and Transit Number

_____ Bank Account Number

_____ Name of the Account Owner

_____ Type of Account: ❒ Checking ❒ Savings

_____ Email Address

_____ 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
reclamacionesindividual@sssvida.com

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PART II — PHYSICIAN'S CERTIFICATION

1. Patient's Name | 2. Age

3. Specific diagnosis for this disability:

4. First examination date
Month ____ Day ____ Year ____

5. Latest examination date
Month ____ Day ____ Year ____

6. Date when first symptoms of the disabling condition appeared:
Month _____ Day _____ Year: _____

7. Date when medical treatment with you began for this condition:
Month _____ Day _____ Year: _____

8. In your opinion, this disability:
❒ Is related to the patient's work or is a result of performing his/her job ❒ Some other kind of accident: _____
❒ Is the result of a car accident ❒ Some other reason: _____

9. Has the patient applied for disability benefits? ❒ Yes ❒ No If "yes", specify: ❒ State Insurance Fund ❒ Social Security ❒ ACCA
If this condition is the result of an accident, state where and when the patient first obtained treatment.
Place: _____ Date: Month _____ Day _____ Year: _____
State any other chronic or acute illnesses the patient previously suffered. _____

10. State if this disability will keep the patient:
❒ Confined at home
❒ Not confined

11. Has the patient had the same condition, or a similar condition? ❒ Yes ❒ No
If "yes", explain: _____

12. Has the patient experienced a disability prior to the current disability? ❒ Yes ❒ No
From: Month___ Day ___ Year ___ To: Month___ Day ___ Year ___
State the diagnosis: _____

13. The patient has been totally and continually disabled to work since:
Month _____ Day _____ Year _____

14. Date when the patient may return to work:
Month _____ Day _____ Year _____

15. Nature of the surgical procedure, if any:
_____
_____
Date performed: Month _____ Day _____ Year _____

16. Date of hospitalization and Hospital name:
_____
_____
Medical Record Number: _____

17. Lab test results (including X-rays, EKG, BMR, EMG, pathology report, etc., and their respective dates)

18. Have you consulted with or referred the case to another physician? ❒ Yes ❒ No
State physician's name, specialty and date: _____
_____

19. Physician's name, specialty and address
_____
_____

License Number:

Telephone No.:

I certify that the above information is my opinion and it truly describes the patient's condition and its approximate duration, and that I am a physician authorized to practice my profession.

_____ Signature

_____ Date

PART III — EMPLOYER'S CERTIFICATION

1. Claimant's Name:

2. Social Security No:

3. Monthly Salary:

4. Last day the claimant worked:
Month_____ Day _____ Year _____

5. Did the claimant return to work?
❒ Yes ❒ No

6. Date when he/she returned to work:
Month_____ Day _____ Year _____

7. The employee's disability is due to: ❒ Illness ❒ Workplace accident ❒ Car accident ❒ Some other kind of accident
❒ Some other reason, explain: _____

8. Is the employee's disability related to his/her work? ❒ Yes ❒ No
Did you fill out a workplace accident report? ❒ Yes ❒ No Date: Month _____ Day _____ Year Case Number: _____

9. Any prior disability before the current one? ❒ Yes ❒ No From: Month _____ Day _____ Year _____ To: Month _____ Day _____ Year _____

10. Specify which tasks the claimant performs as part of his/her job: _____

Corporate Seal

11. Company Name:
_____

Telephone No.:

Address:
_____
_____
_____

I certify that the information I have supplied in this form is true.

_____ Employer's or Authorized Official's Signature

_____ Date