TRIPLE-S VIDA

Accelerated Benefit
Attending Physician's Statement

PATIENTS NAME (please prim)	DATE OF BIRTH
PRESENT ADDRESS (Number & Street)	SOCIAL SECURITY NUMBER
(CITY, STATE, ZIP)	
POSTAL ADDRESS	POLICY NUMBER

Attending Physician's Statement of Disability

The patient is responsible for completion of this form without expense to the Company. Space is available on the reverse side if you wish to amplify your answers. If #5 is not completed in full, claim processing will be delayed

		Mo.	Day	Yr.
1	**HISTORY** When did symptoms first appear?			
2	**PRESENT CONDITION** (a) Subjective symptoms (b) Objective findings *Include results of current x-rays, EKGs or any other special tests relevant to your judgment of prognosis.* (c) Is patient ❒ Ambulatory? ❒ Bed confined? ❒ House confined? ❒ Hospital confined?			
3	**DIAGNOSIS**			
4	**TREATMENT** (a) Date of first visit for above condition (b) Date of most recent visit			
5	**PROGNOSIS** "In my best medical judgment, the above patient's life expectancy is _____"			
6	**MENTAL CONDITION** Is the patient competent to endorse checks and direct the proceeds thereof? ❒ Yes ❒ No			

REMARKS

ATTENDING PHYSICIAN'S NAME (please print)	DEGREE
ADDRESS (Number & Street)	LICENSE NUMBER
(City, Stale, Zip)	TELEPHONE
ATTENDING PHYSICIAN'S SIGNATURE ✓	DATE

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be subject to criminal penalties.

To the Attending Physician: *Please mail this report directly to the address shown below*

TRIPLE-S VIDA, INC.
CLAIMS DEPARTMENT
PO BOX 363786
SAN JUAN PR 00936-3786