TRIPLE-S VIDA

CLAIM FORM
GOOD HEALTH MAINTENANCE

INSURED

Insured'S Name Last Name / Second Last Name / Name / Initial	Social Security Num / /	Policy Num.	
Nombre del Paciente Last Name / Second Last Name / Name / Initial	Social Security Num / /	Date of Birth / / Month Day Year	Sex ❒ M ❒ F
Kinship / Phone	Home Phone	E-Mail	
Mailing Address: Urb, PO Box, HC, RR / Num. / Street / City / Country / Zip Code			
Dirección Residencial: Urb, / Num. / Street / City / Country / Zip Code			

GOOD HEALTH MAINTENACE

REQUIRED DOCUMENTS

Review your policy, identify the preventive test mentioned in the Good Health Maintenance provision, and submit a negative result of the preventive test mentioned in the cancer policy.

- ❒ Mammograms
- ❒ Pap smear
- ❒ Sonomammography
- ❒ Colonoscopy
- ❒ Prostate specific antigen(PSA)
- ❒ Others with similar purpose: ____________________

IMPORTANT NOTICE

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. Act num. 230 of August 9, 2008.

❒ Solicito pago en cheque solamente. Estoy cancelando cualquier autorización previa de depósito directo a mi cuenta.
❒ Estoy notificando que mi número de cuenta bancaria cambió.

notificación de depósito de pago a mi correo electrónico (e-mail).

______________________________ Firma del Asegurado Primario

______________________________ Fecha

¿DESEA RECIBIR SU PAGO DE BENEFICIO DE MANERA RAPIDA Y SEGURA?

Autorización para Pagos Electrónicos de Beneficios a Reclamantes

I authorized Triple-S Vida to initiate credit entry into my personal account in the amount of the benefit payment claimed as owner or beneficiary in the policies issued by Triple-S Vida. I understand that I must submit in writing 30 days in advance any change of account or specific order to cancel this authorization. Please include copy of a void check or any other official evidence.

______________________________ Nombre y Sucursal del Banco

______________________________ Número de ruta y tránsito

______________________________ Número de cuenta bancaria

______________________________ Nombre del Titular de la cuenta

Tipo de cuenta: ☐ Cheque ☐ Ahorro

______________________________ Correo Electrónico (E-mail)

______________________________ Firma Autorizada

______________________________ Fecha de autorización

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