TRIPLE-S VIDA

POLICY CHANGE OR AMENDMENT REQUEST FORM - DEBIT

I. INSURED

Last Name	second Last Name	Name	Initial	Social Security Number
				/ /
Policy Number				Phone:
1.	2.	3.		

II. CANCER POLICY CHANGE OR AMENDMENT

Basic Plan change from: _____ $ _____ To: _____ $_____

PLAN CODE		Individual	Single Parent	Couple	Family
	BENEFIT INCREASE BY UNITS SABU-0715-352 ❒ INCREASE BENEFIT (2 unit) ❒REDUCE BENEFIT (1.5) ❒INCLUDING THE RIDER ❒ REMOVING THE RIDER				
	ORGAN TRANSPLANTS (ETO-1009-282) ❒INCLUDING THE RIDER ❒ REMOVING THE RIDER				
	ACCIDENTAL DEATH, DISMEMBERMENT, HOSPITALIZATION, CONVALESCENCE (EMAHC-0213-300) Suma Asegurada: $_____ Indemnización Mensual $_____ ❒ INCREASE BENEFIT ❒REDUCE BENEFIT ❒INCLUDING THE RIDER ❒ REMOVING THE RIDER				
	HOSPITALIZATION AND CONVALESCENCE DUE TO ILLNESS (EHEC-0609-280) [❒ ($25 daily) $750 monthly ❒ ($50 daily) $1,500 monthly ❒ ($75 daily) $2,250 monthly ❒ ($100 daily) $3,000 monthly] ❒ INCREASE BENEFIT ❒REDUCE BENEFIT ❒INCLUDING THE RIDER ❒ REMOVING THE RIDER				
	INTENSIVE CARE UNIT (ERCI-0609-281) ❒ $250 daily, $15,000 máx. ❒ $350 daily, $21,000 máx. ❒ $500 daily, $30,000 máx. ❒ $650 daily, $39,000 máx. ❒ INCREASE BENEFIT ❒REDUCE BENEFIT ❒INCLUDING THE RIDER ❒ REMOVING THE RIDER				
	BURNS, FRACTURES AND EMERGENCY MEDICAL TREATMENT BENEFIT DUE TO AN ACCIDENT (EQFE-0609-275) ❒INCLUDING THE RIDER ❒ REMOVING THE RIDER				
	FIRST CANCER DIAGNOSIS (EPDC-0609-276) ($1,000 - $50,000) $ _____ ❒ INCREASE BENEFIT ❒REDUCE BENEFIT ❒INCLUDING THE RIDER ❒ REMOVING THE RIDER				
	FIRST HEART ATTACK DIAGNOSIS (EPAC-0609-277) ($1,000 - $10,000) $ _____ ❒ INCREASE BENEFIT ❒REDUCE BENEFIT ❒INCLUDING THE RIDER ❒ REMOVING THE RIDER				
	ONE-TIME PAYMENT FOR RADIOTHERAPY TREATMENT, CHEMOTHERAPY, EXPERIMENTAL THERAPY (SPUR-0816-363) ($1,000 - $50,000) $ _____ ❒ INCREASE BENEFIT ❒REDUCE BENEFIT ❒INCLUDING THE RIDER ❒ REMOVING THE RIDER				
	HOSPITALIZATION FOR 24 HOURS DUE TO AN ACCIDENT SHVA-0715-350 ($1,000 - $2,000) $ _____ ❒ INCREASE BENEFIT ❒REDUCE BENEFIT ❒INCLUDING THE RIDER ❒ REMOVING THE RIDER				
	TOTAL MONTHLY PREMIUM				

III. CHANGE OF INSURED NAME

Attached documentary evidence of the change of the insured name, except for name misspelling.

Previous Name:	New Name:

Reason for the change:

IV. ISSUE AGE CORRECTION

Previous age:	Correct age:

I CERTIFY that the _____ _____, _____ is the correct birth date. Enclosed you will find an original _____ as evidence of the birth date.

Accordingly, I request you:

❒ to notify the amount of money I must pay to maintain the same Insurance Amount; ❒ to refund the amount overpaid;

❒ to adjust the Insurance Amount according to the correct age to maintain in force the same premium payment.

V. PREMIUM OR INSURANCE AMOUNT ADJUSTMENT DUE TO AGE MISTAKENLY STATED

Previous Date:	New Date:

Reason for the change:

If the age for insurance changes, I request you:

❒ to adjust the premium and charge the balance or refund the overpayment ❒ to adjust the Insurance Amount according to the new Insured's age.

VI. PREMIUM AND INSURANCE AMOUNT CHANGE

Previous Plan:	New Plan:

The premium will be adjusted from $_____ to $_____ and the Insurance Amount will be adjusted from $_____ to $_____.

I will submit any evidence or additional insurability requirement in addition to those already presented with this application, no later than 30 days from the date of this request.

VII. ❒ INCLUDE A DEPENDENT* ❒ REMOVE A DEPENDENT

Include documentation to proof the causes of the change: Married Certificate, Birth Certificate, etc

NAME	KINSHIP	BIRTH DATE	SOCIAL SECURITY NUM.
1.			
2.			
3.			
4.			

I AUTHORIZE Triple-S Vida, Inc., 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 any person, except as it is explained above, nor it is being used to guarantee a loan or any type of debt. In addition, no banckruptcy action has been initiated against me.

Signature in _____, Puerto Rico on _____ _____, 20_____.

_____ ASSIGNEE SIGNATURE

_____ INSURED SIGNATURE

_____ IRREVOCABLE BENEFICIARY SIGNATURE

_____ OWNER SIGNATURE (If he/she is different from the Insured)

_____ WITNESS

Owner's address:

_____

_____ Authorized Representative

_____

Debit or Number _____

_____

VII. Dependents that you are including in this policy:

1. ¿Have been denied a life or health Insurance policy?..... ❒Yes ❒No
2. ¿Have been diagnosed or have received medical treatment for any illness or immune deficiency disorder AIDS (Acquire Immunodeficiency Syndrome), ARC (AIDS related-complex) or have you tested positive to AIDS virus antibodies? …… ❒Yes ❒No
3. In the last five years, have received treatment or a doctor has advised medical exams, laboratories or biopsies for the purposed of diagnosed any of the following conditions?
   a. High blood pressure..... ❒Yes ❒No
   b. Internal cancer or melanoma..... ❒Yes ❒No
   c. Cardiovascular system disease..... ❒Yes ❒No
   d. Chronic circulatory problems..... ❒Yes ❒No
   e. Kidney or urinary system disease..... ❒Yes ❒No
   f. Mental illness or nervous system diseases ……..... ❒Yes ❒No
   g. Alcoholism or drug addiction..... ❒Yes ❒No
   h. Diabetes..... ❒Yes ❒No
   i. Respiratory disorders..... ❒Yes ❒No
   j. Any other condition that has not been mentioned ……..... ❒Yes ❒No

❒Yes ❒No

If you answered "Yes" to any of the previous questions, please provide details:

Person's name	Condition	Date	Physician's name and address
		M/_____ Y/_____	
		M/_____ Y/_____	

I CERTIFY that the Authorized Representative asked me all the questions and all my answers have been entered correctly.
I UNDERSTAND that the policy coverage will be in force on the specific date shown on the Insurance Schedule as effective date or until the first premium has been paid.

_____ Proposed Insured Signature

_____ Date

_____ Applicant signature if he/she is not the Proposed Insured Or Witness to the mark signature and address

_____ Authorized Representative Signature

_____ Authorized Representative Num.

_____ Proposed Insured or Owner Signature

CONSENT

I am interested in receiving courtesy reminders, information about future services and events offered or sponsored by Triple-S Vida, Inc. I consent to receiving calls from Authorized Representatives as well as prerecorded, automatically dialed phone calls; voice messages and texts; emails by or on behalf of Triple-S Vida, Inc., on the telephone number(s) and email address I supplied. I understand that this consent is not a condition for obtaining the policy for which I am applying.

Email address:_____ Mobile phone:_____ Home phone:_____

Signature:_____

CONSENT FOR ELECTRONIC DELIVERY OF DOCUMENTS

I AUTHORIZE Triple-S Vida Inc. to deliver by electronic transmission to my last email address, any document that they, by provision of law, are required to deliver, notify, give notice or equivalent terms. I **ACKNOWLEDGE** that I must submit a request in writing to the Triple-S Vida Main Office to revoke this consent and request that they deliver the policy or any other document printed on paper, even after receiving it electronically, at no additional cost. I **CONFIRM** that I have access to a computer with Internet service; an active email account to receive electronic information and in which I can read, download and store documents in Adobe Acrobat PDF format. I understand that I must notify Triple-S Vida of: a) any change of email address; b) that I must update those filters in my account that may prevent me from receiving electronic notifications from Triple S Vida, Inc. I **CONSENT,** in the case of there being more than one insured, that the policy Owner, or in his/her absence the Primary Insured, be the one who receives the information sent electronically. I **AGREE** that a change in the manner of delivery or notification of documents will not take effect until it is registered in our Main Office. It is agreed and understood that the revocation of this authorization will not affect any action that Triple-S Vida, Inc. has taken using this authorization prior to receiving the revocation. I am aware that the company reserves the right to cancel the delivery of the policy or the notification of electronic documents if the emails are returned to Triple-S Vida, Inc.'s server. In this case they will proceed with the delivery or notification on paper. Triple S Vida, Inc. is not required by law to deliver documents or notifications electronically and may discontinue electronic deliveries or notifications partially or completely at any time.

Signature:_____