CLAIM NUMBER _____

Más que un seguro
TOLIC
Trans- Oceanic Life Insurance Company

121 Calle O'Neill, Hato Rey PR 00918
GPO Box 363467 San Juan, PR 00936-3467
TEL. (787) 620-2700 / 1-800-981-8662
FAX (787) 620-2713 http://www.tolic.com
E-mail: servicioalcliente@tolic.com

CLAIM FORM

NOTICE OF CLAIM

___Cancer
___Organ Transplant
___Critical Illness
___ Lump Sum

Hospitalization
___Sickness
___Intensive
___Accident
___Emergency

Payer of Policy: _____ S.S. No. _____ Employee No. _____

Claimant's Data (refers to affected party):
Name _____ S.S. No. _____ Date of Birth: m d y _____
Postal Address_____
Email_____Telephone No. _____
Relationship with Principal Insured: _____

Employer of the payer of the policy: _____

(Please answer all questions)

1. What is the name of the illness or the nature of the injury? _____
2. Date of accident or date first noticed symptoms of illness m d y _____
3. When did you first consult a physician for this condition? m d y _____
4. a. Have you been treated by any other physician during the last two years? Yes _____ No _____
   If answered in the affirmative, indicate the full name of the physician or physicians who treated you: _____
   b. For what condition where you treated? _____
5. Explain: How and when did the accident occur? _____
6. When did you cease working? m d y _____
7. Do you continue under treatment? Yes _____No _____ Explain:_____
8. What is your occupation?_____
9. List the duties of your occupation _____
10. If the claimant is over 19 years, **please include Student Certification.**
11. Claimant's civil status: married ☐ single ☐ separated ☐ divorced ☐

AUTHORIZATION AND CONFIRMATION

I hereby authorize any physician licensed to exercise his profession, hospital, clinic or other medical facility, Insurance Company, the Medical Information Bureau or other organization, institution or persons who have any record or knowledge of my health condition and any member of my family to transfer said information to TOLIC. This authorization will be in effect for a period of 12 months from the date of the claim. A photocopy of this Authorization and Confirmation will be as valid as the original.

IMPORTANT NOTICE

Any person who knowingly and with the intent to defraud presents false information in an insurance claim or who presents assists or ensures the presentation of a fraudulent claim for the payment of a loss or benefit, or files more than one claim for the same damage or loss, will incur in a felony and if convicted will be sanctioned, for each violation, with a fine of not less than Five Thousand Dollars ($5,000) nor more than Ten Thousand Dollars ($10,000) or a penalty of imprisonment for a fixed term of three (3) years, or both penalties. If there are aggravating circumstances, the fixed penalty established may be increased up to a maximum of five (5) years, if there are mitigating circumstances, it may be reduced up to a minimum of two (2) years.

Accepted accordingly:

m d y _____
Date

_____
Signature of Claimant or Legal Representative **

**Legal representative must enclose document certifying the same as such.

Employer

TO BE COMPLETED BY THE CLAIMANT'S EMPLOYER

1. Name of Employee _____ 2. Last day worked m d y _____
3. Kind of job: ____Regular ____Temporary 3a. Shift: ___Full time ___ Part time ___ Contract ____ Transitional
4. Occupational disability: Yes ☐ No ☐ 5. Was an accident or occupational illness report filed with the State Insurance Fund? Yes ☐ No ☐ Indicate reason: _____ Maternity leave: Yes ☐ No ☐ From: m d y To: m d y
6. Did the employee return to work? Yes_____ No _____ If in the affirmative, on what date m d y _____
7. Was there a disability prior to the present one? Yes_____ No_____ From: m d y To: m d y
8. Medical Plan _____ Cost $_____ Payer of Premium _____
9. Effective or renewal date m d y _____

I CERTIFY that I am an authorized representative of the employer of the claimant here named, and that I provide this information to TOLIC and that it is complete and correct.

EMPLOYER _____ Telephone _____
Signature of Human Resources Manager _____ Name in print _____
Signature and Title of another authorized person _____ Date m d y _____

THIS CERTIFICATION WILL NOT BE ACCEPTED IF IT IS NOT COMPLETED AND SIGNED BY THE EMPLOYER

Employer

REPORT OF THE ATTENDING PHYSICIAN

Physician

Name of Patient _____ Age _____

1. Diagnosis: Dx _____ ICD9 Code:_____
2. When you were first consulted for this condition? __m____d____ __y____
3. When the patient felt the first symptoms of this condition? __m____d____y____
4. When did the accident occur? _____
5. What treatment is being provided to the patient? (Therapy, Medications, drugs, etc.) _____
   _____
6. Is this condition due to pregnancy? Yes____ No____ If answered on the affirmative, indicate the date of commencement of pregnancy ___m___d___y_____.
7. Has the patient been given or is the same a candidate for the transplant of any organ? Yes_____ No_____
   Which?_____ Date__m____d____y____
8. If the patient was referred to you, indicate the name of the physician or physicians who have treated him for this condition _____
   _____
9. Did the patient consult any other physician for this condition or conditions that aggravated the same during the last 2 years? Yes ____ No ____
   If yes, explain: _____
10. If there was a fracture or dislocation indicate the type: Open reduction _____ Closed reduction _____
11. Is this accident due to a burn? Yes ____ No_____ Indicate the degree_____ % of body_____
12. If this condition is the result of an accident, indicate when and where first aid was received:
    _____Emergency Room _____Doctor's Office Date _____m____d____y____ Time_____ AM / PM
13. Has the patient had a previous condition that is the same or similar to this one? Yes _____ No _____ If answered in the affirmative, indicate when:__m____d____y____ Describe: _____
14. How long do you estimate the patient will be totally disabled from performing his/her duties? From __m____d____y____ To ___m____d____y____
15. Describe any other illness or ailment that affects the present condition: Dx _____
    _____
16. Since when has patient suffered the same?__d____m____a____
    _____
17. If there was any surgical procedure, indicate: (For "Endoso Quirúrgico" benefit it's necessary to complete and/or submit copy of the Operation Report).
    Description_____
    _____ CPT Code _____ Date __m____d____y____
18. Has the patient been hospitalized previously for any condition? Yes_____ No_____ If answered in the affirmative, indicate
    from __m____d____y____ to __m____d____y____ Diagnosis: Dx_____ ICD9 Code: _____

Additional Comments: _____ _____

Date __m____d____y____

_____ _____
Signature of attending physician Specialty

_____ _____
Name in Print License Number

_____ _____
Address Telephone

Hospital

TO BE COMPLETED BY THE HOSPITAL*

Name of Patient _____ Age _____ Sex _____

Address _____ Social Security _____

Type of Treatment: Ambulatory _____ Hospitalized _____

1. Period of Hospitalization in Regular Room: Admitted_____ Discharged __m____d____y____
2. **Period of Hospitalization in Intensive Care:** Type of Unit _____
   Date Admitted: _____ Time: _____ a.m. ____ p.m. ____
   Date Discharged: __m____d____y____ Time: _____ a.m. ____ p.m. ____
3. Period of Hospitalization in a Coma (loss of consciousness): From: __m____d____y____ To: __m____d____y____
4. Diagnosis and ICD9 Code recorded in the clinical record:_____
   Was this considered as an Accident? Yes___ No ___ If answered in the affirmative, include the bill from the Emergency Room.
5. Dates of prior Admissions at this Hospital._____d____m____a_____ICD9 Code _____

Name of Hospital _____ Employer ID No. _____

Authorized Signature_____ Record No. _____

Name in Print _____ Title _____ Date ___m____d____y____

*If the Hospital does not complete this form, the discharge summary may be used. If admitted to the Intensive Care Unit a certification from the hospital with the date and time of admission and discharge from said area must be submitted.
Not valid without the Hospital's seal.