INSTRUCTIONS FOR PROCESSING YOUR ACCIDENT CLAIM:

Thank you for being part of our great family of members of our supplementary health plans.

This Accident Claim Form must be completed after the initial date of hospitalization or upon discharge. If surgery is required, it should be completed after surgery. Completing this form before the initial date could delay the processing of this claim.

1. Complete and sign Section 1: Primary Insured or Payer Information and Section 2: Covered Insured Information.

2. Have your doctor complete and sign Section 3: Medical Report or submit the Emergency Room evaluation sheet. If you had x-rays or studies, please submit a copy of the radiology report that accompanies the x-rays or studies.

3. If your claim is due to disability, ask your employer to complete and sign Section 4: Employer's Declaration.

4. If you have been hospitalized, you must complete Section 5: Hospital Statement or instead submit a discharge summary.

5. If surgery was performed, include a copy of the surgical report indicating the code or description of the procedure or a copy of the surgical report. These documents can be obtained directly from your medical provider by requesting a **UB-04 (hospital bill) or Health Insurance Claim Form (Form 1500).**

6. If you are claiming for a deceased person, include the Death Certificate with cause of death in its original version. Fill out the Claim for Death form and submit it together with this form.

7. **Direct Deposit:** You can authorize the payment of your claim to be deposited into your bank account. The Authorization for Payment of Direct Deposit Benefits must accompany the claim form **(TOL-FAPBDR-2020).**

Once the form is completed, with the corresponding supporting documentation, please proceed with sending it to the following email or postal address:

E-mail: reclamaciones@tolic.com

Phone: (787) 620-2700
Fax: (787) 620-2713

Postal address
GPO Box 363467, San Juan, PR 00936-3467

Physical address
121 Calle O'Neill, San Juan, PR 00918-2404

Más que un seguro

TOLIC

Trans-Oceanic Life Insurance Company

Accident Claim

Please print. All fields are required.

Section 1: Primary Insured or Payer Information

1. Name:	2. Date of Birth: MM / DD / AAAA	3. SSN:
4. Postal Address:	5. City:	6. ZIP Code:
7. Check this box if this is your permanent address ☐	8. Phone:	9. E-Mail:

Section 2: Covered Insured Information

1. Name:	2. Date of Birth: MM / DD / AAAA	3. SSN:
4. Relationship with the main insured: ☐ Myself ☐ Partner ☐ Dependant	5. Marital status of the covered insured: ☐ Married ☐ Single ☐ Divorced ☐ Student	
6. Explain: How and where did the accident occur?		
7. Occupation:	8. Name of the injury for which you are claiming:	
9. When did the accident happened?: MM / DD / AAAA	10. When did you see your doctor for the first time because of your accident?: MM / DD / AAAA	

AUTHORIZATION AND CONFIRMATION

I hereby authorize any doctor licensed to practice 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 status of health and any member of my family, to transfer such information to TOLIC. This authorization will be in effect for a period of 12 months from the date of the claim. A photostatic copy of this Authorization and Confirmation will be as valid as the original.

IMPORTANT ANNOUNCEMENT

Any person who knowingly and with the intention of defrauding presents false information in an insurance application or, who presents, assists, or causes to present, a fraudulent claim for the payment of a loss or benefit, or presents more than one claim for a same damage or loss, will incur a serious crime and convicted that is, will be sanctioned, for each violation with a fine of not less than five thousand (5,000) dollars, nor more than ten thousand (10,000) dollars or imprisonment for a term fixed three (3) years, or both penalties. If there are aggravating circumstances, the established fixed penalty may be increased to a maximum of five (5) years; should there be extenuating circumstances, it may be reduced to a minimum of two (2) years.

Applicant's Name (Please Print)	Applicant's Signature	Date DD/MM/AAAA

You can send this form by any of the following means:

Email: reclamaciones@tolic.com
Customer Service: Phone: 787.620.2700 **Fax:** 787.620.2713
Postal Address: TOLIC, GPO Box 363467, San Juan, PR 00936-3467

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Accident Claim

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Section 3: Medical Report (completed by Medical Examiner)

1. Patient's Name:
2. Report Date: MM / DD / AAAA
3. SSN:
4. Diagnosis (Dx):
5. Dx Date: MM / DD / AAAA
6. ICD Code:
7. Age:
8. When did the accident or dismemberment occur? Enter the date: MM / DD / AAAA
9. When were you first consulted about the accident? Enter the date: MM / DD / AAAA
10. Indicate where and when you received the first help?: ☐ Emergency Room ☐ Doctor's Office
11. Date: MM / DD / AAAA
12. Is this accident due to a burn?: ☐ Yes ☐ No
13. Please indicate the grade:
14. % of the body (TBS):
15. If there was a fracture or dislocation, indicate what type of treatment: ☐ Open Reduction ☐ Closed Reduction
16. Type of anesthesia: ☐ General ☐ Local ☐ Without Anesthesia
17. If the patient was referred to you, indicate the name of the doctor (s) who have treated the patient for this condition:
18. Has the patient had an injury the same or similar to this one before?: ☐ Yes ☐ No
19. If yes, indicate when: MM / DD / AAAA
20. What treatment is the patient being given? (Therapy, Medications, etc):
21. In the event of a dismemberment, at what height of the limb did the loss occur?:
22. Describe:
23. For how long do you estimate the patient will be totally disabled without being able to work? ☐ N/A
From MM / DD / AAAA Until MM / DD / AAAA
24. Describe any other disease or illness that affects the present condition (Dx):
25. Since when has the patient suffered from it? MM / DD / AAAA
26. If there were any surgical procedures, indicate CPT:
27. Date: MM / DD / AAAA
28. Description:

Additional comments:

29. Examining Physician's Name (Please Print):
30. NPI:
31. Signature:
32. Specialty:
33. Phone Number:
34. Fax:
35. Address:
36. City:
37. State:
38. Zip Code:

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Section 4: Employer's Declaration (completed by employer)

1. Name of the employee:

2. Hiring date: MM / DD / AAAA

3. Date of last work day: MM / DD / AAAA

4. Job type: ☐ Full Time ☐ Temporary ☐ Contract

5. Working day: ☐ Complete ☐ Partial

6. Duration of disability: From MM / DD / AAAA Until MM / DD / AAAA

7. Is the disability occupational? ☐ Yes ☐ No

8. Did you file a report of illness or occupational accident with the State Insurance Fund Corporation? ☐ Yes ☐ No

9. Employee returned to work full time on: MM / DD / AAAA

10. Was there a disability prior to the current one? ☐ Yes ☐ No From MM / DD / AAAA Until MM / DD / AAAA

Fraud Notice:

Any person who knowingly and with the intention of defrauding presents false information in an insurance application or, who presents, assists, or causes to present, a fraudulent claim for the payment of a loss or benefit, or presents more than one claim for a same damage or loss, will incur a serious crime and convicted that is, will be sanctioned, for each violation with a fine of not less than five thousand (5,000) dollars, nor more than ten thousand (10,000) dollars or imprisonment for a term fixed three (3) years, or both penalties. If there are aggravating circumstances, the established fixed penalty may be increased to a maximum of five (5) years; should there be extenuating circumstances, it may be reduced to a minimum of two (2) years.

I certify that I am the authorized representative of the employer of the claimant named here and that the information that I offer to TOLIC is complete and correct.

11. Name of the company / employer:

12. Name of authorized person:

13. Tiltle of the authorized person:

14. Signature of the authorized person:

15. Date: MM / DD / AAAA

16. Phone Number:

17. Fax:

18. E-Mail:

Note: This section is necessary to claim for the disability benefit. Waiver of premium applies when the claimant is the Main Insured and Payer of the policy. This section will not be accepted if it is not completed and signed by your employer.

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Section 5: Hospital Statement (completed by Hospital)

1. Name of patient:			2. SSN:			
3. Age:	4. Gender: ☐ M ☐ F		5. Type of treatment: ☐ Ambulatory ☐ Hospitalization			
6. Diagnosis (Dx):			7. ICD Code:			
8. Period of Hospitalization in regular room:	Admission date:	MM / DD / AAAA	Hour:	HH:MM	☐ AM	☐ PM
	Discharge date:	MM / DD / AAAA	Hour:	HH:MM	☐ AM	☐ PM
9. * Period of Hospitalization in Emergency Room:	Admission date:	MM / DD / AAAA	Hour:	HH:MM	☐ AM	☐ PM
	Discharge date:	MM / DD / AAAA	Hour:	HH:MM	☐ AM	☐ PM
*** Applies in cases where there was no room availability in the hospital and the patient is hospitalized in another area until room availability arises.**						
10. Hospitalization period in intensive care:	Admission date:	MM / DD / AAAA	Hour:	HH:MM	☐ AM	☐ PM
11. Unit Type:	Discharge date:	MM / DD / AAAA	Hour:	HH:MM	☐ AM	☐ PM
12. Period of Hospitalization in a state of Coma:	Admission date:	MM / DD / AAAA	Hour:	HH:MM	☐ AM	☐ PM
	Discharge date:	MM / DD / AAAA	Hour:	HH:MM	☐ AM	☐ PM
13. Date of previous Admissions to this Hospital:	From:	MM / DD / AAAA	Until:	MM / DD / AAAA		
14. Diagnosis Dx:			15. ICD Code:			

Hospital Seal:		
	16. Hospital Name:	
	17. File number:	
	18. Name of authorized person:	
	19. Signature of the authorized person:	20. Date: MM / DD / AAAA
	21. Phone Number:	22. Fax:
	23. E-Mail	

Note: This section will not be accepted if it is not completed, signed and struck with the official seal of the Hospital.

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Trans-Oceanic Life Insurance Company

Authorization for Payment of Direct Deposit Benefits

Please print. All fields are required.

Primary Insured Information

1. Name of the Main Insured	2. E-Mail
3. Mailing Address of the Main Insured	4. Telephone

Bank Information

1. Financial Institution	2. Route Number
3. Account Number	4. Account Type ☐ Checking ☐ Savings

AUTHORIZATION

I hereby request and authorize Trans-Oceanic Life Insurance Company (TOLIC) to send to me the full amount of benefits claimed under the terms and conditions established in my policies, as long as my claim is eligible for payment. I authorize said payment to be made by electronic funds transfer (EFT) to the checking or savings account at the financial institution indicated on this form. In addition, I consent and authorize TOLIC to carry out a debit request in the event that I have made any overpayment, payment in error or payment after my death, for which I consent and authorize the financial institution designated in this form to refund said amount to TOLIC. In the event that the bank account provided in this Form is a joint account, that is, that there are other account holders besides myself, I release TOLIC from responsibility for the payment of benefits that I make of my policies through said account, if totally or partially it is subject to any action of freezing and / or seizure of funds; if, in whole or in part, said benefit payment is withdrawn from the account by any of the account holders; If, in whole or in part, the aforementioned payment could not be used and / or withdrawn from the account due to court orders that establish it or due to the death of any of the account holders, as well as for any other situation that is unrelated to TOLIC .

This authorization for the payment of benefits by direct deposit will remain in effect until: (1) TOLIC determines to rescind it and / or render it without effect; (2) TOLIC receives and processes a written notice from me rendering it without effect; or (3) the financial institution indicated in this authorization notifies TOLIC in writing of its termination. Any change of bank account or private order to revoke this authorization must be submitted in writing with no less than five (5) days in advance. Together with this authorization, I include a copy of a canceled check from said account and / or other bank evidence that allows me to validate that I am the account holder. I acknowledge that the direct deposit payment mechanism represents an entirely discretionary method provided by TOLIC to facilitate the payment of my claim and that it is under no obligation to do so. I hereby accept that, if for any reason TOLIC could not process the payment of my claim for benefits to the account indicated here, it will be sent to me by check via regular mail.

IMPORTANT NOTICE

Any person who knowingly and with the intention of defrauding presents false information in an insurance application or, who presents, assists, or causes to present, a fraudulent claim for the payment of a loss or benefit, or presents more than one claim for a same damage or loss, will incur a serious crime and convicted that is, will be sanctioned, for each violation with a fine of not less than five thousand (5,000) dollars, nor greater than ten thousand (10,000) dollars or imprisonment for a term fixed three (3) years, or both penalties. If there are aggravating circumstances, the established fixed penalty may be increased to a maximum of five (5) years; if there are extenuating circumstances, it may be reduced to a minimum of two (2) years.

______________________	______________________	DD/MM/AAAA ______________
Applicant's Name	Applicant's or Legal Representative Signature	Date

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