INSTRUCTIONS FOR PROCESSING YOUR CLAIM FOR MAINTENANCE OF GOOD HEALTH:

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

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

2. Include with this form a copy of the results of the study performed so we can proceed to evaluate your claim.

3. **Direct Deposit:** You can authorize the payment of your claim to be deposited into your bank account. The Authorization form for Payment of Benefit by Direct Deposit 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

Más que un seguro

TOLIC

Trans-Oceanic Life Insurance Company

Claim for Good Health Maintenance

Please print. All fields are required.

Section 1: Primary Insured or Payer Information

1. Payer Name:	2. SSN:

Section 2: Covered Insured Information

1. Name:	2. SSN:	3. Date of Birth: DD / MM / AAAA
4. Postal Address (If there was a change in Postal Address, please update it):		5. City:
6. Postal Address:	7. Phone Number:	8. E-mail:
9. Relationship with the Main Insured: ☐ Myself ☐ Partner ☐ Dependant		
10. Please mark the proof for which you are claiming the benefit: ☐ Mammography ☐ Sonomamography ☐ Papanicolaou ☐ Colonoscopia ☐ PSA ☐ Spiral CT ☐ Other		
11. If you checked another, indicate which:	12. Day of exam: DD / MM / AAAA	
13. Have you received treatment or been diagnosed with Cancer ?: ☐ Yes ☐ No		
14. Diagnosis:	15. Diagnosis Date: DD/MM/AAAA	

IMPORTANT: Please include with this form a copy of the results of the study performed so we can proceed to evaluate your claim.

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	DD/MM/AAAA Date

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

Más que un seguro

TOLIC

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

AUTORIZATION

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 or joint account, that is, that there are other account holders besides myself, I release and totally 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.

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

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