INSTRUCTIONS FOR PROCESSING YOUR CLAIM FOR ILLNESS:

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

This Claim for Illness form must be completed after the initial date of hospitalization or upon discharge. Forms completed 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, maternity leave or premium waiver under the cancer policy, 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 Discharge Summary with diagnosis.

5. If your claim is for cancer, you must include the Pathology report where the cancer was diagnosed. (The hospital or physician will provide this report upon request). If the cancer condition was diagnosed by an oncologist, please present certification with date of diagnosis. In cases of Pernicious Diseases, you must submit a copy of the studies where said condition was confirmed for the first time, together with the certification of the specialist doctor.

6. Submit all bills related to this claim, including ambulance, radiation treatment, chemotherapy, etc. All bills must be itemized and include diagnosis, dates, and charges for services.

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

8. If surgery was performed, include a copy of the surgeon's bill that indicates the code or description of the procedure or a copy of the operative report.

9. These documents can be obtained directly from your medical provider by requesting a UB-04 (hospital bill) or Health Insurance Claim Form (Form 1500).

10. 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 Number: (787) 620-2700
Fax: (787) 620-2713

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

Physical Address

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TOLIC
Trans-Oceanic Life Insurance Company

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TOLIC

Trans-Oceanic Life Insurance Company

Claim for Illness

Please print. All fields are required.

Section 1: Primary Insured or Payer Information

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

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 insured covered: ☐ Married ☐ Single ☐ Divorced ☐ Student	
6. Occupation:	7. Name of the disease for which you are claiming:	
8. When did the first symptoms appear? MM / DD / AAAA	9. When did you see your doctor for the first time for this condition? MM / DD / AAAA	
10. Have you visited a doctor in the last two years? ☐ Yes ☐ No	11. Doctor's Name:	
12. Reason for visit:		

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 state 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 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 (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 Number: 787.620.2700 | **Fax:** 787.620.2713
Postal Address: TOLIC, GPO Box 363467, San Juan, PR 00936-3467

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Claim for Illness

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Section 3: Medical Report (completed by Medical Examiner)

1. Patient's Name:		2. Date of the Report: MM / DD / AAAA	3. SSN:
4. Diagnosis (Dx):	5. Date Dx: MM / DD / AAAA	6. ICD Code:	7. Age:
8. When did the first symptoms of this condition appear? MM / DD / AAAA		9. When was this condition consulted for the first time? MM / DD / AAAA	
10. Is this condition due to pregnancy? ☐ Yes ☐ No		11. If you answered yes, indicate the date of the beginning of the pregnancy: MM / DD / AAAA	
12. Has the patient undergone or is he a candidate for an organ transplant? ☐ Yes ☐ No		13. Which one?	14. Transplant date: MM / DD / AAAA
15. What treatment is being given to the patient? (Therapy, Medications, etc):			
16. If the patient was referred to you, indicate the name of the doctor (s) who have treated the patient for this condition:			
17. Has the patient had a condition the same or similar to this before? ☐ Yes ☐ No		18. If you answered yes, indicate when: MM / DD / AAAA	
Describe:			
19. How long do you estimate the patient will be totally disabled without being able to work? From: MM / DD / AAAA Until: MM / DD / AAAA			
20. Describe any other disease or illness that affects the present condition (Dx):		Since when has the patient suffered from it? MM / DD / AAAA	
21. If there was any surgical procedure, indicate CPT:		22. Date: MM / DD / AAAA	
Description:			
23. Has the patient been hospitalized before for any other condition? ☐ Yes ☐ No		24. If you answered yes, please indicate ICD:	
From: MM / DD / AAAA Until: MM / DD / AAAA		25. Diagnosis (Dx):	
26. Name of Examining Physician (Please Print):	27. NPI:	28. Signature:	
29. Specialty:	30. Phone Number:	31. Fax:	
32. Address:	33. City:	34. State:	35. Zip Code:

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

1. Name of Employee:	
2. Contract date: MM / DD / AAAA	3. Date of last working day: MM / DD / AAAA
4. Type of Employment: ☐ Regular ☐ Part Time ☐ Contract	5. Working hours: ☐ Full Time ☐ Part Time
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. Did you activate the maternity leave? ☐ Yes ☐ No From: MM / DD / AAAA Until: MM / DD / AAAA	
10. Employee returned to work full time at: MM / DD / AAAA	
11. Was there a disability prior to the current one? ☐ Yes ☐ No From: MM / DD / AAAA Until: MM / DD / AAAA	

Fraud Notice:

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

12. Name of the company / employer:	
13. Name of the authorized person:	
14. Title of authorized person:	
15. Signature of the authorized person:	16. Date: MM / DD / AAAA
17. Phone Number:	18. Fax:
19. Email	

Note: This section is necessary to claim for the benefit of disability, maternity leave and waiver of premium for cancer. 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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Claim for Illness

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Section 5: Hospital Statement (completed by Hospital)

Important Notice

This section is necessary to claim for the hospitalization benefit of your policy if you do not submit form UB-04 or Discharge Summary. Remember that these documents can be obtained directly from your medical service provider (s). These forms serve to expedite the processing of your claim.

1. Patient's Name:			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. Hospitalization period in intensive care:	Admission date: MM / DD / AAAA	Hour: HH:MM	☐ AM ☐ PM			
10. Unit Type:	Discharge date: MM / DD / AAAA	Hour: HH:MM	☐ AM ☐ PM			
11. Date of previous Admissions to this Hospital:	From: MM / DD / AAAA	Until: MM / DD / AAAA				
12. Diagnosis (Dx):			13. ICD Code:			
Hospital Seal:	14. Hospital Name:					
	15. File Number:					
	16. Name of the authorized person:					
	17. Signature of the authorized person:		18. Date: MM / DD / AAAA			
	19. Phone Number:		20. Fax:			
	21. Email:					

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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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.

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