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NOTICE OF CLAIM	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hospitalization
<input type="checkbox"/> Organ Transplant	<input type="checkbox"/> Sickness
<input type="checkbox"/> Critical Illness	<input type="checkbox"/> Intensive
<input type="checkbox"/> Lump Sum	<input type="checkbox"/> Accident
	<input type="checkbox"/> Emergency

CLAIM FORM

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)

- What is the name of the illness or the nature of the injury? _____
- Date of accident or date first noticed symptoms of illness _____ m d y
- When did you first consult a physician for this condition? _____ m d y
- 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 were you treated? _____

- Explain: How and when did the accident occur? _____

- When did you cease working? _____ m d y
- Do you continue under treatment? Yes _____ No _____ Explain: _____

- What is your occupation? _____
- List the duties of your occupation _____
- If the claimant is over 19 years, **please include Student Certification.**
- 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.

TO BE COMPLETED BY THE CLAIMANT'S EMPLOYER

- Name of Employee _____
- Last day worked _____ m d y
- Kind of job: Regular Temporary 3a. Shift: Full time Part time Contract Transitional
- 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
- Did the employee return to work? Yes _____ No _____ If in the affirmative, on what date _____ m d y
- Was there a disability prior to the present one? Yes _____ No _____ From: _____ m d y To: _____ m d y
- Medical Plan _____ Cost \$ _____ Payer of Premium _____
- 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

EMPLOYER

