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NOTICE OF	NOTICE OF CLAIM	
Cancer Organ Transplant Critical Illness Lump Sum	HospitalizationSicknessIntensiveAccident Emergency	

CLAIM NUMBER_

CLAIM FORM

		<u> </u>	
Pay	er of Policy: S.S. No.	Employee No	
Claimant's Data (refers to affected party): Name			
Emp	ployer 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. 3. 4.		у у у	
	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? YesNo 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.		
	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.			
1	Accepted according	ıy.	
	Date Signature of C	aimant or Legal Representative **	
	**Legal representative mu	st enclose document certifying the same as such.	

**Legal representative must enclose document certifying the same as such.
TO BE COMPLETED BY THE CLAIMANT'S EMPLOYER
1. Name of Employee 2. Last day worked ^m d y
1. Name of Employee
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: dy To: dy_
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? YesNo 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
THIS CERTIFICATION WILL NOT BE ACCEPTED IF IT IS NOT COMPLETED AND SIGNED BY THE EMPLOYER

	REPORT OF THE ATTENDING PHYSICIAN		
Nan	ne of Patient Age		
1. 2. 3. 4.	Diagnosis: Dx ICD9 Code: When you were first consulted for this condition?m d y When the patient felt the first symptoms of this condition?m d y 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 d y		
7.	Has the patient been given or is the same a candidate for the transplant of any organ? Yes No Which? Datem dy If the patient was referred to you, indicate the name of the physician or physicians who have treated him for this condition		
8.			
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 RoomDoctor'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 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		
18.	Has the patient been hospitalized previously for any condition? Yes No If answered in the affirmative, indicate fromm d v to _m d y Diagnosis: Dx ICD9 Code:		
Add	litional Comments:		
Date	e m d y		
	Signature of attending physician Specialty		
_	Name in Print License Number		
	Address Telephone		
	TO BE COMPLETED BY THE HOSPITAL*		
	me of Patient Age Sex		
	dress Social Security pe of Treatment: Ambulatory Hospitalized		
1 y i	Period of Hospitalization in Regular Room: Admitted Discharged dy_		
2.	Period of Hospitalization in Intensive Care: Type of Unit		
	Date Admitted: Time: a.m p.m		
_	Date Discharged: dy Time: a.m p.m		
3.	Period of Hospitalization in a Coma (loss of consciousness): From: m d y To: m d y		
4.	· • · · · · · · · · · · · · · · · · · ·		
5.	Was this considered as an Accident? Yes No If answered in the affirmative, include the bill from the Emergency Room. Dates of prior Admissions at this Hospital d a ICD9 Code		
Nai	me of Hospital Employer ID No		
Aut	thorized Signature Record No.		
Nai	me in Print Date		

^{*}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.