

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



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 <input type="checkbox"/>	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: <input type="checkbox"/> Myself <input type="checkbox"/> Partner <input type="checkbox"/> Dependant	5. Marital status of the covered insured: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> 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	

Note: If the claimant is a dependent child over 19 years of age, please include Student Certification (must be a student at the time of the accident).

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.

DD/MM/AAAA

Applicant's Name (Please Print)

Applicant's Signature

Date

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

Please print. All fields are required.

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?: <input type="checkbox"/> Emergency Room <input type="checkbox"/> Doctor's Office				11. Date: MM / DD / AAAA	
12. Is this accident due to a burn?: <input type="checkbox"/> Yes <input type="checkbox"/> No		13. Please indicate the grade:		14. % of the body (TBS):	
15. If there was a fracture or dislocation, indicate what type of treatment: <input type="checkbox"/> Open Reduction <input type="checkbox"/> Closed Reduction					
16. Type of anesthesia: <input type="checkbox"/> General <input type="checkbox"/> Local <input type="checkbox"/> 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?: <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> 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 have 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:

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

Please print. All fields are required.

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: <input type="checkbox"/> Full Time <input type="checkbox"/> Temporary <input type="checkbox"/> Contract	5. Working day: <input type="checkbox"/> Complete <input type="checkbox"/> Partial
6. Duration of disability: From MM/DD/AAAA Until MM/DD/AAAA	
7. Is the disability occupational? <input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Did you file a report of illness or occupational accident with the State Insurance Fund Corporation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Employee returned to work full time on: MM/DD/AAAA	
10. Was there a disability prior to the current one? <input type="checkbox"/> Yes <input type="checkbox"/> No From MM/DD/AAAA Until MM/DD/AAAA	
<p>Fraud Notice:</p> <p>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.</p>	
<p>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.</p>	
11. Name of the company / employer:	
12. Name of authorized person:	
13. Title of the authorized person:	
14. Signature of the authorized person:	15. Date: MM/DD/AAAA
16. Phone Number:	17. Fax:
18. E-Mail:	
<p>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.</p>	

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

Please print. All fields are required.

Section 5: Hospital Statement (completed by Hospital)

1. Name of patient:		2. SSN:	
3. Age:	4. Gender: <input type="checkbox"/> M <input type="checkbox"/> F	5. Type of treatment: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Hospitalization	
6. Diagnosis (Dx):		7. ICD Code:	
8. Period of Hospitalization in regular room:		Admission date: MM / DD / AAAA	Hour: HH:MM <input type="checkbox"/> AM <input type="checkbox"/> PM
		Discharge date: MM / DD / AAAA	Hour: HH:MM <input type="checkbox"/> AM <input type="checkbox"/> PM
9. * Period of Hospitalization in Emergency Room:		Admission date: MM / DD / AAAA	Hour: HH:MM <input type="checkbox"/> AM <input type="checkbox"/> PM
		Discharge date: MM / DD / AAAA	Hour: HH:MM <input type="checkbox"/> AM <input type="checkbox"/> 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 <input type="checkbox"/> AM <input type="checkbox"/> PM
11. Unit Type:		Discharge date: MM / DD / AAAA	Hour: HH:MM <input type="checkbox"/> AM <input type="checkbox"/> PM
12. Period of Hospitalization in a state of Coma:		Admission date: MM / DD / AAAA	Hour: HH:MM <input type="checkbox"/> AM <input type="checkbox"/> PM
		Discharge date: MM / DD / AAAA	Hour: HH:MM <input type="checkbox"/> AM <input type="checkbox"/> 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.

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

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 <input type="checkbox"/> Checking <input type="checkbox"/> 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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