INSTRUCTIONS FOR PROCESSING YOUR CLAIM FOR DEATH:

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

1. Complete and sign the Claim for Death form.

2. Include the following documents with your Claim for Death Form:

   A. Documents related to the Deceased Insured:
      I. Original policy or statement for the loss of it.
      II. Original of the Certificate of Birth or Baptism of the deceased insured.
      III. Original of the Death Certificate with the cause of death.

   B. Documents related to the Claimant Applicant:
      I. Identification with portrait and signature of the claimant.
      II. Copy of the claimant's Social Security.
      III. Original of the Marriage Certificate in the case of the deceased Insured's spouse.
      In the case of a consensual couple, and in the absence of a Marriage Certificate, a Declaration Sworn on the fact of coexistence in public and evident form of the claimant applicant with the deceased insured.

   C. Documents related to the Beneficiaries:
      I. If the beneficiary or one of them is a minor, they must submit:
         a. Original of the Birth Certificate of the minor (s).
         b. Certified copy of the document by which the minor's guardian is appointed.
         c. Name and postal address of the minor's guardian.
         d. Complete the OAT 1032 form of the General Court of Justice (Information on the Beneficiary of Accounts under the Custody of the Court) for each beneficiary that is a minor.

   If at the time of death the insured has not survived the designated beneficiary, or dies after the insured, and there is no other named beneficiary, nor is there a named contingent beneficiary, you must submit:
      I. Original Death Certificate of the beneficiary (s).

3. In case of death by Accident, please include the following documents:
   A. Final police report.
   B. Autopsy and toxicology report.

4. If it is the first claim under the Cancer Policy, please include the Pathology report where the deceased insured was diagnosed with cancer. (The hospital or doctor will provide this report upon request). If the cancer diagnosis was made based on clinical information, rather than pathological findings, please present the evidence that established the cancer diagnosis. In cases of Pernicious Diseases, you must submit a copy of the studies where said condition was confirmedfor the first time, together with the certification of the specialist doctor.

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 Death

Please print. All fields are required.

Section 1: Primary Insured or Payer Information

1. Name of Main Insured:	2. Date of Birth: MM / DD / AAAA	3. SSN:	4. Policy Number:
5. Postal Address:		6. City:	7. ZIP Code:
8. Check this box if the mailing address is your permanent address: ☐	9. Phone Number:	10. E-Mail:	
11. Name of the Beneficiary:	12. Date of Birth: MM / DD / AAAA	13. Beneficiary's Social Security:	
14. Relationship with the deceased:	15. Telephone of the Beneficiary:		
16. Postal Address of the Beneficiary:	17. City:	18. Postal Address:	

Section 2: Covered Insured Information

1. Name of the Deceased Insured:	2. Date of Birth: MM / DD / AAAA	3. SSN:
4. Policy Number:	5. Date of death: MM / DD / AAAA	

6. The cause of death was due to: ☐ A. Disease	Name the disease	Date of disease onset MM / DD / AAAA
☐ B. Accident	Please briefly describe	Date of accident MM / DD / AAAA
☐ C. Other (indicate which)		

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.

Notes: (1) To include the data of more beneficiaries, request an additional page. It is required to complete the OAT 1032 form of the General Court of Justice for each beneficiary who is a minor. (2) In case of legal representative, present evidence.

Applicant's Name (Please Print)	Signature of the applicant	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

Estado Libre Asociado de Puerto Rico
TRIBUNAL GENERAL DE JUSTICIA
Tribunal de Primera Instancia
Sala Superior de _____

Información sobre el (la) Beneficiario(a) de Cuentas bajo la Custodia del Tribunal

Instrucciones: Favor de completar en computadora, a máquina o en letra de molde. Archive en el expediente. De ocurrir algún cambio en la información aquí presentada, deberá actualizar la misma sometiendo un nuevo documento en la Secretaría del Tribunal.

Información sobre el (la) Beneficiario(a)

1. Nombre
Apellido Paterno *Apellido Materno* *Nombre* *Inicial*

2. Número del Caso: _____

3. Dirección Postal:
Apartado de Correo *Pueblo*
Estado *Zip Code*

4. Dirección Residencial:
Urbanización *Calle Número* *Pueblo*
Estado *Zip Code*

5. Marque con una (X): ☐ Menor ☐ Incapacitado(a)

6. Números de teléfono: Residencial: ( ) - -

7. Fecha de Nacimiento: _____ / / _____
(día/mes/año)

Trabajo: ( ) - - Celular: ( ) - -

Información del Padre, Madre o Tutor(a)

8. Nombre
Apellido Paterno *Apellido Materno* *Nombre* *Inicial*

9. Parentesco con Beneficiario(a): _____

10. Dirección Postal:
Apartado de Correo *Pueblo*
Estado *Zip Code*

11. Dirección Residencial:
Urbanización *Calle Número* *Pueblo*
Estado *Zip Code*

12. Números de teléfono: Residencial: ( ) - - Trabajo: ( ) - – Celular: ( ) - –

Información del Familiar más Cercano que no Viva con el (la) Beneficiario(a)

13. Nombre
Apellido Paterno *Apellido Materno* *Nombre* *Inicial*

14. Parentesco con Beneficiario(a): _____

15. Dirección Postal:
Apartado de Correo *Pueblo*
Estado *Zip Code*

16. Dirección Residencial:
Urbanización *Calle Número* *Pueblo*
Estado *Zip Code*

17. Números de teléfono: Residencial: ( ) - – Trabajo: ( ) - – Celular: ( ) - -

Información Sobre la Cuenta

18. Banco:
Banco *Sucursal*

19. Número de Cuenta: _____

20. Depósito Inicial: $ _____