INSTRUCTIONS FOR PROCESSING YOUR CLAIM FOR CONTINUITY OF DISABILITY:

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

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.
3. If you are being cared for by the State Insurance Fund Corporation (CFSE), please submit Form 1021 (Medical Certificate) or Form 395 (with date of Treatment While Working (CT) or Discharge).
4. Ask your employer to complete and sign Section 4: Employer's Declaration.
5. 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 form 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
121 Calle O'Neill, San Juan, P.R. 00918-2404

Más que un seguro
TOLIC
Trans-Oceanic Life Insurance Company

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Trans-Oceanic Life Insurance Company

Please print. All fields are required.

Claim for Disability Continuity

Requested Benefit
Disability Continuity
Claim Number:

Section 1: Primary Insured or Payer Information

1. Name:	2. Date of Birth: DD/MM/AAAA	3. Social Security of the Payer:
4. Postal Address:	5. City:	6. ZIP Code:
7. Check box if mailing 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: ☐ Married ☐ Single ☐ Divorced ☐ Sudent	
6. Postal Address:	7. City:	8. ZIP Code:

Information Requirement:

1. If reported to the State Insurance Fund Corporation, please provide the **updated Form 1021**.
2. In case of being discharged or working with treatment (CT), please include **Form 395**.

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.

_____	_____	DD/MM/AAAA _____
Applicant's Name (Please Print)	Applicant's Signature	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 Disability Continuity

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Section 3: Medical Report (completed by Medical Examiner)

1. Patient's Name:	2. Age:
3. When were you first consulted about this condition? DD/MM/AAAA	4. When did the patient's total disability begin? DD/MM/AAAA
5. When will the patient be able to work under treatment? Since: DD/MM/AAAA	
6. Is the patientstill totally disabled and unable to work? ☐ Yes ☐ No If yes, Until when: DD/MM/AAAA	
7. Additional Comments:	
8. Diagnosis of disability:	
9. Name of Examining Physician (Please Print):	10. NPI:
11. Specialty:	12. Date of the Report: DD/MM/AAAA
13. Address:	
14. Phone Number:	

Name of the Examining Physician (please print)	Signature of the Examining Physician	DD/MM/AAAA Date

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Claim for Disability Continuity

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

1. Employee's name:		2. Last day of work: DD/MM/AAAA
3. Was the employee discharged by the State Insurance Fund or by your doctor? ☐ Yes ☐ No		If yes, when: DD/MM/AAAA
4. Did the employee return to work? ☐ Yes ☐ No	If so, on what date: DD/MM/AAAA	
5. Maternity Leave: ☐ Yes ☐ No	From: DD/MM/AAAA	Until: DD/MM/AAAA
6. Medical Plan:	7. Cost:	8. Premium Payer:
9. Effective or renewal date: DD/MM/AAAA		

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

10. Employer:	11. Phone Number:

Name of the Human Resources Manager (Please Print)

Signature of the Human Resources Manager

Signature and title of Authorized Person

DD/MM/AAAA

Date

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