INSTRUCTIONS FOR PROCESSING YOUR INITIAL DISABILITY CLAIM:

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, Section 2: Covered Insured Information and Section 2B: Information on Health Condition.

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. If your claim arises for Illness within the first 2 years from the effective date of your Physical Disability coverage, you must include a copy of your medical record with the doctor who treats you from the first symptoms for the claimed condition.

6. 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, PR 00918-2404

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TOLIC
Trans-Oceanic Life Insurance Company

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Please print. All fields are required.

Claim for Initial disability

Requested Benefit
Initial disability
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. Civil Status: ☐ Married ☐ Single ☐ Divorced ☐ Student	
6. Postal Address:	7. City:	8. ZIP Code:

2B: Information on Health Condition:

1. Cause of Disability: ☐ Illness ☐ Accident ☐ Other (indicate which)	2. Describe the illness or accident:
3. When did you feel the first symptoms of your illness or on what date did the accident occur? MM / DD / AAAA	4. When did you first see the doctor for the illness or accident? MM / DD / AAAA
5. Have you been seen by any other doctor in the last two years? ☐ Yes ☐ No	
6. If you answered yes to the previous question, indicate the full name of the doctor or doctors who treated you and the condition that treated you:	

Name of the doctor	Conditions
A.	
B.	
C.	
7. Is your condition work related? ☐ Yes ☐ No	8. How did the accident occur?
9. Where did the accident occur?	10. When did you stop working? MM / DD / AAAA
11. Occupation:	12. What are your tasks in your occupation?

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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.

Applicant's Name (Please Print)	Applicant's Signature	DD/MM/AAAA Date

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Section 3: Medical Report (completed by Medical Examiner)

1. Patient Name:		2. Age:
3. Diagnosis (Dx):	4. ICD Code:	
5. When did the symptoms first appear or when did the accident occur? DD/MM/AAAA	6. When did the patient first experience symptoms of this condition? DD/MM/AAAA	
7. Is this condition due to pregnancy? ☐ Yes ☐ No	8. When was this condition consulted for the first time? DD/MM/AAAA	
9. If the patient was referred to you, indicate the name of the doctor (s) who have treated the patient for this condition:		
10. Did the patient see any other doctor for this condition or conditions that aggravated them during the past 2 years? ☐ Yes ☐ No	Explain:	
11. If there was a fracture or dislocation, indicate which type: Open Reduction:	Closed Reduction:	
12. Is this accident due to a burn? ☐ Yes ☐ No	13. Indicate the grade	14.% of the body:
15. If this condition is the result of an accident, indicate where and when you received the first help: ☐ Emergency room ☐ Doctor's Office	16. Date: DD/MM/AAAA	17. Hour: ☐ AM ☐ PM
18. Has the patient had a condition the same or similar to this before? ☐ Yes ☐ No	19. If the answer is yes, indicate when: DD/MM/AAAA	
Describe:		
20. Describe any other disease or ailment that affects the present condition (Dx):	Since when did the patient suffer from it	
21. If there was any surgical procedure, indicate:		
22. Description:	23. CPT Code:	24. Date: DD/MM/AAAA
25. For how long do you estimate the patient will be totally disabled and unable to work? From: DD/MM/AAAA	Until: DD/MM/AAAA	
26. For how long will the partially incapacitated patient be able to work under treatment? From: DD/MM/AAAA	Until: DD/MM/AAAA	
Additional comments:		

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27. Has the patient been hospitalized before for any condition? ☐ Yes ☐ No From: DD/MM/AAAA Until: DD/MM/AAAA	
28. Diagnosis (Dx)	29. ICD Code:
30. Has your patient filed for disability benefits? ☐ Yes ☐ No	If yes, specify: ☐ State Insurance Fund ☐ SSN ☐ ACAA

Name of the Examining Physician (please print)

Signature of the Examining Physician

License number

Specialty

Address

Phone Number

DD/MM/AAAA

Date

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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. Type of employment: ☐ Regular ☐ Temporary ☐ Full Time ☐ Part Time ☐ Contract ☐ Transitory			
4. Occupational disability: ☐ Yes ☐ No		5. Did you file an accident or occupational disease report in the State Insurance Fund Corporation? ☐ Yes Date: DD/MM/AAAA ☐ No	
If the previous answer was no, indicate the reason:			
6. Maternity Leave: ☐ Yes ☐ No From: DD/MM/AAAA Until: DD/MM/AAAA			
7. Indicate the case number of the State Insurance Fund. Case Number:		8. Did the employee returned to work? ☐ Yes ☐ No If yes, when: DD/MM/AAAA	
9. Was there a disability prior to the current one? ☐ Yes ☐ No From: DD/MM/AAAA Until: DD/MM/AAAA			
10. Medical Plan:	11. Cost: $	12. Premium Payer:	13. 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.

		DD/MM/AAAA
Employer	Phone Number	Date
Name of the Human Resources Manager (Print)	Signature of the Human Resources Manager	Signature and title of Authorized Person

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