INSTRUCTIONS FOR PROCESSING YOUR ILLNESS CLAIM:

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

This Claim for Illness form must be completed after the initial date of hospitalization or upon discharge. Forms that are completed 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.

3. If you have been hospitalized, you must complete Section 4: Hospital Statement or instead submit a Discharge Summary with diagnosis.

4. If your claim is for cancer, you must include the Pathology report where the cancer was diagnosed. (The hospital or doctor will provide this report upon request). If the cancer condition was diagnosed by an oncologist, please present certification with date of diagnosis.

5. Submit all bills related to this claim, including ambulance, radiation treatment, chemotherapy, etc. All bills must be itemized and include diagnosis, dates, and charges for services.

6. If you are claiming for a deceased insured, 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. If surgery was performed, include a copy of the surgeon's invoice that indicates the code or description of the procedure or a copy of the operative report.

8. These documents can be obtained directly from your healthcare provider by requesting a UB-04 (hospital bill) or Health Insurance Claim Form (Form 1500).

9. **Direct Deposit:** You can authorize your claim payment to be deposited into your bank account. The Authorization for Payment of Direct Deposit Benefits form must accompany the claim form (TOL-FAPBDR-2020). It must include a copy of a canceled check from said account and / or other bank evidence that allows the account to be validated.

10. Once the form has been completed, with the corresponding supporting documentation, please proceed with sending it to the following email or postal address:

E-mail: claims@tolic.com

Phone: 1-800-981-8662

Postal Address: PO BOX 691628 Orlando, FL 32869

Physical Address: 4700 Millenia Blvd Suite 500 Orlando, FL 32839

Going Beyond TOLIC

Trans-Oceanic Life Insurance Company Of America

Going Beyond TOLIC
Trans-Oceanic Life Insurance Company Of America

Claim for Illness

Please print clearly. All fields required.

Section 1: Primary Insured or Payer Information

1. Name:	2. Date of Birth: DD/MM/AAAA	3. Payer's SSN:
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 of the covered insured: ☐ Married ☐ Single ☐ Divorced ☐ Student	
6. Occupation:	7. Name of the disease for which you are claiming:	
8. When did the first symptoms appear? MM / DD / AAAA	9. When did you see the doctor for the first time for this condition? MM / DD / AAAA	
10. Have you visited a doctor in the last two years? ☐ Yes ☐ No	11. Doctor's Name:	
12. Reason for visit:		

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 valid 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 intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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: claims@tolic.com
Customer Service: 1-800-981-8662
Postal Address: PO BOX 691628 Orlando FL, 32869 **Physical Address:** 4700 Millenia Blvd Suite 500 Orlando FL, 32839

Going Beyond TOLIC
Trans-Oceanic Life Insurance Company Of America

Claim for Illness

Please print clearly. All fields required.

Section 3: Medical Report (completed by Medical Examiner)

1. Patient's Name:		2. Date of the Report: MM / DD / AAAA	3. SSN:
4. Diagnosis (Dx):	5. Dx Date: MM / DD / AAAA	6. ICD Code:	7. Age:
8. When did the first symptoms of this condition appear? MM / DD / AAAA		9. When was this condition consulted for the first time? MM / DD / AAAA	
10. Is this condition due to pregnancy? ☐ Yes ☐ No		11. If the answer is yes, indicate the date of the beginning of the pregnancy: MM / DD / AAAA	
12. Has the patient undergone or is a candidate for an organ transplant? ☐ Yes ☐ No		13. Which?	14. Transplant date: MM / DD / AAAA
15. What treatment is being given to the patient? (Therapy, Medications, etc):			
16. If the patient was referred to you, indicate the name of the doctor (s) who have treated the patient for this condition:			
17. Has the patient had a condition the same or similar to this before? ☐ Yes ☐ No		18. If you answered yes, indicate when: MM / DD / AAAA	
Describe:			
19. For how long do you estimate the patient will be totally disabled without being able to work? ☐ Does not apply Since: MM / DD / AAAA Until: MM / DD / AAAA			
20. Describe any other disease or illness that affects the present condition (Dx):		Since when have the patient suffered from it? MM / DD / AAAA	
21. If there was any surgical procedure, indicate CPT:		22. Date: MM / DD / AAAA	
Description:			
23. Has the patient been hospitalized before for any other condition? ☐ Yes ☐ No		24. If the answer is yes, indicate ICD:	
From: MM / DD / AAAA Until: MM / DD / AAAA		25. Diagnosis (Dx):	
26. Name of Examining Physician (Please Print):	27. NPI:	28. Signature:	
29. Specialty:	30. Phone Number:	31. Fax:	
32. Address:	33. City:	34. State:	35. ZIP Code:

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

Email: claims@tolic.com
Customer Service: 1-800-981-8662
Postal Address: PO BOX 691628 Orlando FL, 32869 **Physical Address:** 4700 Millenia Blvd Suite 500 Orlando FL, 32839

Going Beyond TOLIC
Trans-Oceanic Life Insurance Company Of America

Claim for Illness

Please print clearly. All fields required.

Section 4: Hospital Statement (completed by Hospital)

Important announcement

This section is necessary to claim for the hospitalization benefit of your policy if you do not submit form UB-04 or Discharge Summary. Remember that these documents can be obtained directly from your medical service provider (s). These forms serve to expedite the processing of your claim.

1. Patient's Name:			2. SSN:			
3. Age:	4. Gender: ☐ M ☐ F		5. Type of treatment: ☐ Ambulatory ☐ Hospitalization			
6. Diagnosis (Dx):			7. ICD Code:			
8. Period of Hospitalization in regular room:	Admission date: MM / DD / AAAA	Hour: HH:MM	☐ AM ☐ PM			
	Discharge date: MM / DD / AAAA	Hour: HH:MM	☐ AM ☐ PM			
9. Hospitalization period in intensive care:	Admission date: MM / DD / AAAA	Hour: HH:MM	☐ AM ☐ PM			
10. Unit Type:	Discharge date: MM / DD / AAAA	Hour: HH:MM	☐ AM ☐ PM			
11. Date of previous Admissions to this Hospital:	Since: MM / DD / AAAA	Until: MM / DD / AAAA				
12. Diagnosis Dx:			13. ICD Code:			
Hospital Seal:	14. Hospital Name:					
	15. File Number:					
	16. Name of the authorized person:					
	17. Signature of the authorized person:		18. Date: MM / DD / AAAA			
	19. Phone Number:		20. Fax:			
	21. Email:					

Note: This section will not be accepted if it is not completed, signed and punched out with the official seal of the Hospital.

Fraud Notice:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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

Email: claims@tolic.com
Customer Service: 1-800-981-8662
Postal Address: PO BOX 691628 Orlando FL, 32869 **Physical Address:** 4700 Millenia Blvd Suite 500 Orlando FL, 32839

Going Beyond TOLIC
Trans-Oceanic Life Insurance Company Of America

Authorization for Payment of Direct Deposit Benefits

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 ☐ Checking ☐ 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 intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Applicant's Name	Applicant's or Legal Representative Signature	DD/MM/AAAA Date

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

Email: claims@tolic.com
Customer Service: 1-800-981-8662
Postal Address: PO BOX 691628 Orlando FL, 32869 **Physical Address:** 4700 Millenia Blvd Suite 500 Orlando FL, 32839