INSTRUCTIONS TO PROCESS YOUR CLAIM FOR PREVENTION:

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. Please include a copy of the results of the study carried out and evidence of expenses incurred by the Insured.

3. Direct Deposit: You can authorize your claim payment to be deposited into your bank account. The Authorization for Payments 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.

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 Number: 1-800-981-8662

Postal Address: PO BOX 691628 Orlando, FL 32869

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

TOLIC Going Beyond
Trans-Oceanic Life Insurance Company Of America

Claim for Prevention

Please print. All fields are required.

Section 1: Primary Insured or Payer Information

1. Name:	2. SSN:

Section 2: Covered Insured Information

1. Name:	2. SSN:	3. Date of Birth: DD / MM / AAAA
4. Postal Address (If there was a change in the Postal Address, please update it):		5. City:
6. ZIP Code:	7. Phone Number:	8. E-mail:
9. Relationship with the Primary Insured: ☐ Myself ☐ Partner ☐ Dependant		
10. Please mark the study for which you are claiming the benefit: ☐ Mammography ☐ Sonomammography ☐ Pap smear ☐ Colonoscopy ☐ PSA ☐ Spiral CT ☐ Other		
11. If you checked another, please indicate which:	12. Exam date: DD / MM / AAAA	
13. Have you received treatment or been diagnosed with Cancer ?: ☐ Yes ☐ No		
14. Diagnosis (Dx):	15. Date of diagnosis (Dx): DD/MM/AAAA	

Please include the following documents:
☐ Copy of the result of the study carried out
☐ Health Insurance Claim Form (Form 1500)

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 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.

DD/MM/AAAA

Applicant’s Name   Applicant’s Signature   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

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.

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

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