Multinational Life Insurance Company
— Seguro te Responde —

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REQUEST FORM OF BENEFITS BASIC COVERAGE WITH CANCER AND FEARED DISEASES

☐ CANCER PLAN PLATIUM ☐ CANCER OPTIMAL PLAN ☐ ADVANTAGE (N) ☐ MILLEMIUM (M) ☐ OTHER

PART A **INSTRUCTIONS**: Please complete this form according to what applies for the claim of benefits and include the documents that correspond to your claim.

√ **Select benefit that you claim:**	► **Required Documents**
☐ FIRST DIAGNOSTIC → $________ Expenses	• Reading of pathology where indicated positive diagnosis. Expense or invoices of studies, laboratories, X-Rates and biopsy done, before the date of test of pathology. **Complete parts A-B and C of the claim form.**
☐ HOSPITALIZATION → Quantity of Nights ________ (num.)	• Invoice of hospitalization that indicate diagnosis, date of admission and Discharge from hospital. **Complete parts A-B and C of the claim form.**
☐ INTENSIVE CARE → Quantity of Nights ________ (num.)	• Invoice of hospitalization with the breakdown of the dates that you were admitted in intensive care unit and diagnostic results. **Complete parts A and B of the claim form.**
☐ SURGERY → $________ Expenses	• Expense or invoices of surgical procedures, Notes of surgical procedures that include CPT, Notes of anesthesia. **Complete parts A and B of the claim form.**
☐ TREATMENT QUIMIO AND RADIATIONTHERAPIES → $________ Expenses	• Expenses or invoices of chemotherapies or radiation therapies. **Complete parts A and B of the claim form.**
☐ FAMILY DOCTOR → Quantity of Days ________ (num.)	• Invoice of Expensive of Family Doctor while being hospitalized. **Complete parts A-B and C of the claim form.**
☐ SERVICE NURSES → Quantity of Days ________ (num.)	• Invoice that includes: Name, address, number of license, date of service and shift that worked. **Complete parts A and B of the claim form.**
☐ EXPENSE OF FUNERAL → $________ Expenses	• Invoice of funeral expenses and death Certificate (RD-77 Rev. 1/89). **Complete parts A and B of the claim form.**
☐ OTHERS → $________ Expenses	Please indicate other benefits that you claim. ________________

***** Anti-fraud Notice *****

"Any person that knowingly provides false information with the intention defraud, present any false information that is requested by the Insurance Company or, in any way that I presented, or helped or supplied any fraudulent claim for the payment of a loss or another benefit, or to presented more than one claim for the same damage or loss, this act will incur in guilty and serious crime that, will be sanctioned, by each violation with a penalty of a find not smaller than five thousand (5,0000) dollars, nor higher than ten thousand (10,000) dollars or suffers of imprisonment by a fixed term of three (3) years, or both penalties. To mediate circumstances aggravating, the fixed penalty established can be able to be enlarge to a maximum of five (5) years, to mediate mitigating circumstances, will be able to be reduced to minimum of two (2) years".

PART B **FOR TO BE COMPLETED BY THE POLICYHOLDER (PRINT)**

1 Number of the policy:	2. Complete name of the main policyholder:	3. Social Security number of the main policyholder:
4 Date of birth of the patient:	5. Complete name of the patient:	6. Social Security number of the patient:
7. Number of telephone: (Home)	8. Postal Address:	9. Relationship of the main policyholder: ☐ spouse ☐ dependent son
10. Number of telephone: (Work)		12. Date of diagnostic exam (biopsy)
11. E-mail address:	13. Diagnostic	

Have you received treatment or medical attention for cancer's conditions in the last (5) years? ☐ **YES** ☐ **NO** (If its answer is **YES,** please give detail information at the back of this page)

Certification and/or authorization: I certify that all the information supplied by my person, in this form is correct. I know that the law imposes severe punishments, like fines, jail or both penalties to discretion on the Court, by offering false information with purpose of obtaining benefits of the insurance. I authorize all the doctors, hospitals and other institutions that attended me, to my spouse or to my dependent children, to supply to MULTINATIONAL LIFE INSURANCE COMPANY any information concerning this request. I authorize my employer to give information to MULTINATIONAL LIFE INSURANCE COMPANY or to deliver information or necessary documents to determine my benefits.

SIGNATURE OF THE MAIN POLICYHOLDER ____________ DATE ____________

SIGNATURE OF THE PATIENT (applies only when is of legal age) ____________ DATE ____________

PART C	FOR IT TO BE COMPLETED BY THE FAMILY DOCTOR (PRINT)
1. Name of the patient:	2. Nature of the illness and code of diagnostic ICD-9:
3. When the symptoms were noted for the first time? Date:	4. When the patient consulted him for the first time on this condition? Date:
5. Did the patient have this or any similar symptoms before? ☐ **YES** ☐ **NO** (If the answer if **YES**, describe it) Date:	
6. Has the patient received any treatment or medical attention for cancerous conditions in the last five (5) years? ☐ **YES** ☐ **NO** (If the answer if **YES**, explain in detail):	
7. Indicate date and results of the pathological exam: Date: ______________________ Results: ______________________	

Any person, including insurance agent, broker or Insurance medical or any other health services supplier, or an employer, that nowly, I helped or I participated in doing a false representation in fact or to submit incomplete information, knowing that the information is not correct, to insert in a request of insurance or in a report or statement (claim) in relation to said insurance, would be considered to have committed fraud for effects Of the Code of Insurances. Seeing Article 27.190 of the Code of Insurance

REPORT OF SERVICES

Date of services	Location	Describe the nature of the services provided, either by doctors or surgical	Expenses

Name of the doctor (print):	Number of license:	Specialty
Postal Address of the doctor:		

Certification: I certify that the information before offered is based on a probability and medical need and that it is true and correct to my understanding.

______________________ Signature of Doctor

______________________ Date

______________________ Telephone number (Doctor's Office)

COMMENTS: ____

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