Chubb Insurance Company
of Puerto Rico
33 Resolucion STE 500
San Juan, PR 00920

P.O. Box 191249
San Juan, PR 00919-1249
T 787-274-4700
T 1-787-758-6989

# Requirements for Medical Expenses Reimbursement

Dear Insured,

Committed to providing you with the excellent service you deserve, it is necessary that you submit all the documentation detailed below**: (We reserve the right to request additional documents if required)**

☐ **Medical report and treatment:** It must include the date of onset of the condition, evolution, and a definitively signed diagnosis by your doctor.
☐ **Copy of evidence and/or proof of all medical expenses incurred.**
☐ **Copy of the record of the first medical assistance received and/or hospital visit.**
☐ **Copy of results from any conducted studies** (ex. laboratory tests, x-rays, etc.)
☐ **Copy of valid photo identification of the insured issued by a government entity with authority to issue it (front and back):** If you are a citizen of the United States of America, identifications issued by both the federal government and any of its jurisdictions will be accepted. If you are not a citizen of the United States of America, only a valid national passport will be accepted.
☐ **Accident or illness notice:** (complete the attached document in print letters).

You can begin your claims process by sending your information by regular mail to the following address:

**Chubb Insurance Company of Puerto Rico,** PO Box 191249, San Juan, PR 00919-1249. You can also send your claim by fax to 787-758-6989 or by email to: puertorico-firstnoticeofloss@chubb.com.

The requested information is required to initiate the process of your claim. **Claims that do not meet all the previously requested documentation will not be accepted.**

Article 27.320-Notice by the Insurance Commissioner

"Any person who knowingly, and with the intent to defraud, submits false information in an insurance application or who submits, helps, or makes fraudulent claims for payment of a loss or other benefit, or presents more than one claim for the same damage or loss is guilty of a felony and, regardless of conviction, shall be fined not less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000) or imprisoned for a fixed term of three (3) years, or both. In case of aggravating circumstances, the fixed penalty established may be increased up to a maximum of five (5) years; in case of mitigating circumstances, it may be reduced to a minimum of two (2) years."

**I certify that the information provided by me on this form is correct.**

_____

Signature

(Or legal representative)

Date

(mm-dd-yyyy)

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# Notice of Accident or Illness

To claim for medical expenses coverage related to my condition of _____ with a diagnosis date of the _____ of _____ in the year _____.

| | | | |
|---|---|---|---|
| Name | | | |
| Postal Address | | | |
| Residential Address | | | |
| Birth Date (m-d-y) | | Policy Number | |
| Phone Number | | Email | |
| Detailed description of what happened | | | |

**Authorization**

I hereby authorize any hospital, physician or any other person who has treated or examined me, any other entity or organization in general, to provide Chubb Insurance Company or its representatives, any information regarding any illness or injury suffered by me; medical history, consultations and/or treatments, and to provide information or copies of all records or files in their archives. A photocopy of this authorization must be considered as valid and effective as the original. Note: Please include a copy of your identification card or driver's license to request the above.

In _____ on the _____ day of _____ in the year _____.

**If the person is a minor, indicate the relationship of the person signing this authorization.**

_____

Signature Relationship

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**" I certify that the information provided by me on this form is correct.**

_____

Signature
(or legal representative)

Date
(mm-dd-yyyy)