P.O. BOX 9023547
SAN JUAN PR 00902-3547
787.758.2500

DISMEMBERMENT CLAIM FORM – LOSS OF VISION, FEET, AND HANDS

SECTION I. INFORMATION ABOUT THE INSURED

1) INSURED'S NAME:

Father's surname _____ Mother's surname _____ Name _____ Initial _____

2) Birth date	3) Occupation:	4) Gender	5) Social Security Number	6) Marital status:
Month Day Year		F ☐ M ☐	☐☐☐-☐☐-☐☐☐☐	Single ☐ Married ☐ ☐

7) Date of accident:	8) Date of desmemberment:	9) Date of vision, hearing or speech loss:
Month Day Year	Month Day Year	Month Day Year

10) Phone number:	12) Email:	13) Employer name and group number information:
11) Cellphone number:		

14) Physical address:
Urb./Cond. *Number* *Street* *City* *State* *Zip code*

15) Mailing address:
PO Box *City* *State* *Zip code*

Beneficiary Claimant

SECTION II. INFORMATION ABOUT THE POLICY OWNER OR HOLDER

1) Name of the policyholder or insured group:	3) Start date of the insured's employment: Month day Year
2) Policy number:	4) Employment termination date of the insured: Month Day Year
5) If the claim payment proceeds, please indicate the delivery: ☐ Send to the beneficiary ☐ Send to the policyholder	6) Name of the person completing this section: 7) Occupation or position of the person completing this section: 8) Signature: 9) Date:

I CERTIFY that the statements contained in Section I are true and accurate to the best of my knowledge and belief.

FRAUD NOTICE

Any person who knowingly and with intent to defraud submits false information on an insurance application, or who presents, assists, or causes to be presented a fraudulent claim for the payment of a loss or other benefit, or submits more than one claim for the same damage or loss, commits a felony and, upon conviction, shall be penalized for each violation with a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravating circumstances exist, the fixed term may be increased to a maximum of five (5) years; if mitigating circumstances exist, it may be reduced to a minimum of two (2) years.

You are hereby advised that you have continuous duty and responsibility to provide accurate information. Should any change occur to the information provided in this application, you must notify us immediately. If any information not supplied by you arises or is discovered that in any way affects or modifies your right to the requested benefit, whether received or to be received, you will be held responsible for such modification or outcome for failing to provide the correct information or failing to update it.

AUTHORIZATION AND CONSENT TO DISCLOSE INFORMATION

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR §164.508, and for the purpose of assisting MCS in processing a hospitalization benefit claim, I authorize any physician, healthcare professional, pharmacy, hospital, employer, insurance company, medical examiner, governmental agency or entity, or organization that possesses medical, employment, official documents, police reports, or any other pertinent documentation, to grant MCS or its representatives the authority to review, copy, or obtain copies of any medical details, employment information, police records, or any other information or documentation relevant to the insurance claim.

This includes but is not limited to: mental and physical conditions, medical evaluations, diagnoses, treatments, prognoses, autopsy protocols, psychiatric treatment, laboratory and toxicology tests—specifically regarding drugs and alcohol—as well as tests or treatment for HIV/AIDS and sexually transmitted diseases. This authorization is for the exclusive use of MCS and shall not be limited by the absence of identification or the name of the person to whom the authorization is directed in the request for information.

This authorization will remain valid for the duration of the claim process. You have the right to revoke this authorization by providing written notice, signed and dated, to MCS. Once revoked, the protected health information subject to this authorization will no longer be used or disclosed, except to the extent that it has already been used. By signing this authorization, you acknowledge that the disclosed information may be re-disclosed and will no longer be protected under HIPAA privacy regulations. You have the right to retain a copy of this authorization and to inspect and receive any information disclosed under its terms. A photocopy of this authorization shall be considered as effective and valid as the original.

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Insured's Signature _____ Date _____

DISMEMBERMENT CLAIM FORM –
LOSS OF VISION, FEET, AND HANDS

1) Patient's name

_____ _____ _____ _____
Father's surname Mother's surname Name Initial

2) Birth date

Month Day Year

___/_____/_____

3) Medical record number

_____

4) Date when symptoms first appear:

Month Day Year

__/_____/_____

5) Fecha en que el(la) paciente le consultó médicamente por primera vez:

Month Day Year

__/_____/_____

6) At the time of the initial consultation, was there visible evidence of trauma? If yes, please explain: Yes ☐ No ☐

_____

7) Indicate whether the patient previously had the same condition or a similar one. If yes, provide the date when the condition occurred and the treatment received.

Yes ☐ No ☐

8) Primary or initial diagnosis: _____

9) Diagnosis code (CPT- ICD-10): _____

Final diagnosis: _____

DISMEMBERMENT OF HANDS

A. Indicate which body part has been affected:
☐ Right hand ☐ Left hand

B. Level of amputation: _____

C. Is the amputation non-traumatic? For example, but not limited to: dysvascular, infectious, neoplastic, congenital.
Yes ☐ No ☐ Explain: _____

D. Date of amputation: _____

E. Name of the hospital where the amputation was performed: _____

F. Name of the physician who performed the surgery: _____

According to your medical opinion, was the amputation the result of an accidental bodily injury? Yes ☐ No ☐ Explain: _____

VISION LOSS

A. Visual acuity: With eyeglasses: right eye _____ left eye _____ **Without eyeglasses**: right eye _____ left eye _____

B. Could vision be improved with treatment? Yes ☐ No ☐ Explain: _____

C. In your opinion, is the loss of vision complete and irreversible? Yes ☐ No ☐ Explain: _____

D. In your opinion, is the loss of vision solely the result of an accidental bodily injury?
Yes ☐ No ☐ Explain: _____

E. If there is total loss of vision, when did this loss occur? Date: _____

DISMEMBERMENT OF FEET

A. Indicate which body part has been affected:
☐ Right foot ☐ Left foot

B. Level of amputation: _____

C. Is the amputation non-traumatic? For example, but not limited to: dysvascular, infectious, neoplastic, congenital.
Yes ☐ No ☐ Explain: _____

D. Date of amputation: _____

E. Name of the hospital where the amputation was performed: _____

F. Name of the physician who performed the surgery: _____

According to your medical opinion, was the amputation the result of an accidental bodily injury? Yes ☐ No ☐ Explain: _____

Doctor's name: _____ Signature: _____

License number: _____ Email: _____

Address: _____ Phone: _____

DISMEMBERMENT INSURANCE – LOSS OF VISION, FEET, AND HANDS

CLAIM DOCUMENTATION

In addition to this form, please find below the list of initial documentation that must be submitted along with your claim:

- ☐ A true and exact copy of the medical record from the attending physician for the claimed health condition.
- ☐ A true and exact copy of the hospital record.
- ☐ If the accident was reported to the Puerto Rico Police, a true and exact copy of the police report, once the investigation has been completed.

The aforementioned documentation serves as a guide and provides initial evidence for the evaluation of your claim. We reserve the right to request any additional documentation or information that we deem necessary to analyze and investigate your claim.

Once you have completed the form, you may submit it via email to:
segurodevidacommercial@medicalcardsystem.com; or by postal mail to:

MCS Life Insurance Company– Claims Department, 11th Floor

P.O. Box 9023547 San Juan, PR 00902-3547

MCS PLAZA
255 Ponce de León Ave., Suite 106
San Juan PR 00917-1919