



DEPARTMENT OF
LABOR
AND HUMAN RESOURCES
GOVERNMENT OF PUERTO RICO

**APPLICATION FOR DISABILITY BENEFITS FOR WORKERS
COVERED BY ACT 139
(INDUSTRIAL AND AGRICULTURAL PHASE)**

INSTRUCTIONS

This form should be completed in all its parts if you are an agricultural or industrial worker covered by the Temporary Non-Occupational Disability Insurance under the plan administered by the Puerto Rican Government (**SINOT**, its acronym in Spanish). If a private plan or a self-insured employer covers you for SINOT, you must complete their corresponding form. Use blue or black ink to complete this form. Include your initials whenever correcting errors.

The Disability Benefits Act requires the application to be filed not later than three (3) months following the beginning of disability. If filed later, you must explain the reason(s) for the late filing.

Part A, CLAIMANT'S REPORT should be completed in all its parts by the disabled worker. Write the Social Security number clearly, and all the exact dates that are required. Answer all the questions. The Social Security number will be used for contributing purposes only.

Each employer for whom you are working at present must complete **Part B EMPLOYER'S REPORT**. Be sure that the required information is complete. Do not leave this form at your employer's office, because this could cause delays in the processing of your disability benefits. The worker is responsible for the correct and prompt processing of this form, as states our SINOT Act. However, you can delegate the filing of your SINOT claim to whomever you find pertinent, if you are unable to move to do so by your disability.

Each Doctor, Chiropractor or Psychologist from which you are receiving treatment, must complete **Part C MEDICAL OR PSYCHOLOGICAL CERTIFICATE** (each one using a separate form of Part C). Also the Medical Guard of the Records of the institution, in which you are receiving or have received treatment, should complete this form in Part C. The Doctor, Chiropractic or Psychologist has to be authorized to exert his profession in Puerto Rico or the site of their residence.

Conserve copy of this form for future claim.

Once it has been completed this application for disability benefits, mail it to the following address:

**Department of Labor and Human Resources
Bureau of Benefits to the Workers
Disability Insurance Program
PO BOX 195540
San Juan Puerto Rico 00919-5540**

OFFICIAL USE

Central Office				Local Office of			
Received		Given back		Received		Given back	
Date(M-D-Y)	By	Date(M-D-Y)	By	Date(M-D-Y)	By	Date(M-D-Y)	By

TEMPORARY NON-OCCUPATIONAL DISABILITY INSURANCE PROGRAM