

PART B

EMPLOYER'S REPORT

1. Worker's name:		2. Social Security Num:	3. Employee's number:
4. Occupation:	5. Weekly Salary \$ _____ month \$ _____	6. Regular weekly schedule _____ hours	7. Requires license to make its tasks? YES <input type="checkbox"/> NO <input type="checkbox"/>
8. Are you assured voluntarily with the Act Num. 139 of 1968? Yes <input type="checkbox"/> No <input type="checkbox"/> Workers included _____		9. The worker contribute to: Chauffeurs Insurance <input type="checkbox"/> Disability Insurance (SINOT) <input type="checkbox"/> _____%	
10. Employer's contribution to Disability Insurance (SINOT) _____%		11. Last date physically worked (month-day-year)	12. Effective suspension in (month-day-year)
13. Reason for unemployment:		14. Date returned to work (month-Day-Year):	
15. Job - related disability: Yes <input type="checkbox"/> No <input type="checkbox"/> Accident report date (month-day-year) _____ SIF Case Num (C.F.S.E.) _____		16. Car related disability: Yes <input type="checkbox"/> No <input type="checkbox"/>	
17. Are the workers covered for the SINOT by authorized a private plan or self-insured approved by the Secretary of Labor? Yes <input type="checkbox"/> NO <input type="checkbox"/> In affirmative case, indicate, Plan number _____ Assurance Company _____			
18. Have you made any payment during the worker's disability? Yes <input type="checkbox"/> No <input type="checkbox"/> In affirmative case, indicate:			

KIND OF PAYMENT	AMOUNT GROSS	TOTAL DAYS	PERIOD		DATE OF PAYMENT (month -Day-Year)
			FROM (month-Day-Year)	Through (month -Day-Year)	
<input type="checkbox"/> Vacations					
<input type="checkbox"/> Sick leave					
<input type="checkbox"/> Maternity leave					
<input type="checkbox"/> Voluntary Pay <input type="checkbox"/> Exemption <input type="checkbox"/> Payroll					
<input type="checkbox"/> Pension o retirement					
<input type="checkbox"/> Holiday pay Which are?					
<input type="checkbox"/> Others (Specify)					

19. If this is a maternity claim under Act 3, indicate the weekly wage or average used for the payment by the Act Núm. 3 of 1942: \$ _____.
If there was no payment, explain:

20. Company's Name:			
Postal Address:		Local Address:	
Phone:		E-mail:	
Fax:		FEDERAL account number	
Unemployment and Disability Insurance Account Number	<input type="text"/>		<input type="text"/>

21. QUARTERS WORKED*	YEAR	WAGES
January to March	2	\$
April to June	2	\$
July to September	2	\$
October to December	2	\$

Submit evidence: Copy quarterly lists and cancelled checks.

22. In case of **AGRICULTURAL WORK, COMPLETE:**
Farm's name and number:

CERTIFICATION

I certify that the information I am submitting in this form is correct. I know that the Act 139, in Section 11 (a), imposes severe penalties---as it fines, jail or both pains, to discretion of Court-by offering deception relative to a claim of disability benefits.

Employer name (or authorized representative, in printed)	Position
Employer's signature (or authorized representative)	Date (month -day-year)

OFFICIAL USE

THE EMPLOYER HAS PRIVATE PLAN YES <input type="checkbox"/> NO <input type="checkbox"/>	Authorized civil employee	THE PLAN IS CONTRIBUTORY: SI <input type="checkbox"/> NO <input type="checkbox"/>	Authorized civil employee
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