COMMONWEALTH OF PUERTO RICO
Department of Labor and Human Resources

DI-1 Amn. Sept. 2011

APPLICATION FOR DISABILITY BENEFITS 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 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 Workers Benefits
Disability Insurance Program
PO BOX 195540
San Juan Puerto Rico 00919-5540

OFFICIAL USE

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

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

PART A **CLAIMANT´S REPORT**

1. Name (Last name, and/or husband, and first name) (PRINT LETTER)	2. Social Security Number **(For contribution use only)**	3. Sex [ ] M[ ] F
4. Postal address : (Include "Zip Cod	5. Residential address: Phone	
6. Date of birth (month-day-year)	7. Occupation:	8. Before becoming disabled, I worked until: Date (month-day-year)

9. My employers during the last 18 months were [State the companies´ names and addresses, dates of employment, and if you worked at the same time for more than one employer (Part B) for each one.]

a)	b)
From_____ To_____ (month-day-year) (month-day-year)	From_____ To_____ (month-day-year) (month-day-year)

10. During my disability: ☐ I received ☐ I am receiving ☐ I am managing benefits or income of:

	YES	NO	GROSS AMOUNT		YES	NO	GROSS AMOUNT
a. My employer or union	☐	☐	$	c. Social Security for Chauffeurs Date (month -day-year)	☐	☐	$
Vacation pay Date (month-day-year)	☐	☐		d. Social Security (Disability)* Date (month -day-year)	☐	☐	
Sick leave Date (Month-day-year)	☐	☐		d. Social Security (Retirement)* Date (Month-day-year)	☐	☐	
Maternity leave Date (month-day-year)	☐	☐		e. State Insurance Fund Corporation (CFSE)* Date (month -day-year)	☐	☐	
Pension o retirement* Date (month -day-year)	☐	☐		f. ACAA´S Insurance Date (month -day-year)	☐	☐	
Holidays Date (month -day-year)	☐	☐		g. Veterans Date (month -day-year)	☐	☐	
Voluntary Pay Date (month -day-year)	☐	☐		h. A Private Plan Date (month -day-year)	☐	☐	
b. Unemployment Insurance Date (month -day-year)	☐	☐		i. Other (Specify) Date (month -day-year)	☐	☐	

*** In affirmative case, you must send copy of the letter of approval of Social Security or Pension and copy of documents of the CFSE, if it applies**

11. I became disabled (Explain how, where and when your disability occurred. Include number of the complaint of the Police, if it applies).	12. My disability is related to... (In affirmative case, it includes copy of the determination or documents.) **YES** **NO** [ ] [ ] My Job SIF Claim No.(CFSE)_____ [ ] [ ] An automobile accident
13. When I became disabled, I was: [ ] employee (a) [ ] unemployed (a)	14. During my disability I worked the period: From_____ To_____ (month-day-year) (month-day-year)
15. I recovered and I am able to work from: Date (month-day-year) 16. I returned to work in: Date (month-day-year)	17. Are you do payments to ASUME? Yes ☐ No ☐

18. I am giving this application after three (3) months of the beginning of my disability for the following reasons:

CERTIFICATCION AND AUTHORIZATION

I certify that I am or I was disabled to work and that all the information provided by my in this form is certain. I know that the Law, in its Sections 3 (o) and 11 (a), imposes serious punishments---as it fines, jail or both pains, to discretion of Court-by offering deception in order to obtain disability benefits. I authorize my employer and doctor or any other natural or legal people, to provide to the Disability Insurance Program (SINOT) of the Department of Labor and Human Resources, all the information necessary for the processing of my application.

Claimant´s Signature (or mark, if unable to sign)	**Date (month-day-year)**
Witness´ name (Printed)	Witness' address:
Witness´ signature	Phone:

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PART B **EMPLOYER´S REPOR**

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☐ NO ☐
8. Are you assured voluntarily with the Act Num. 139 of 1968? Yes ☐ No ☐ Workers included_____		9. The worker contribute to: Chauffeurs Insurance ☐ Disability Insurance (SINOT) ☐ _____%	
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 ☐ No ☐ Accident report date (month-day-year)_____ SIF Case Num (C.F.S.E.)_____		16. Car related disability: Yes ☐ No ☐	

17. Are the workers covered for the SINOT by authorized a private plan or self-insured approved by the Secretary of Labor? Yes ☐ NO ☐
In affirmative case, indicate, Plan number_____ Assurance Company_____

18. Have you made any payment during the worker´s disability?
Yes ☐ No ☐ In affirmative case, indicate:

KIND OF PAYMENT	AMOUNT GROSS	TOTAL DAYS	PERIOD FROM (month-Day-Year)	PERIOD Through (month -Day-Year)	DATE OF PAYMENT (month -Day-Year)
☐ Vacations					
☐ Sick leave					
☐ Maternity leave					
☐ Voluntary Pay ☐ Exemption ☐Payroll					
☐ Pension o retirement					
☐ Holiday pay Which are?					
☐ 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: Fax:	E-mail:
Unemployment and Disability Insurance Account Number ☐☐☐☐☐☐☐☐☐☐	FEDERAL account number ☐☐-☐☐☐☐☐☐☐

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

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

Submit evidence: Copy quarterly lists and cancelled checks.

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 ☐ NO ☐	Authorized civil employee	THE PLAN IS CONTRIBUTORY: SI ☐ NO ☐	Authorized civil employee

PART C **MEDICAL OR PSYCHOLOGICAL CERTIFICATE**

1. Patient's: name

2. Medical record number:

3. Disability related to:	**YES**	**NO**
The Job	☐	☐
An automobile accident	☐	☐

4. Diagnosis (Medical data that, to your knowledge, disables the patient). **USE MEDICAL DIAGNOSTIC CODE).** Specify the complications, if the incapacity is by pregnancy**.**

5. Treatment period (month-day-year)

From_____ To _____

6. Disability period (month-day-year)

From_____To_____

7. In case of pregnancy or abortion it indicates (month-day-year)

Probably delivery date:_____

Delivery date:_____ Abortion date:_____

9. Date of the dismemberment or the loss of total and permanent sight **(month-day-year)**

10. If the dismemberment or the loss of the total and permanent sight, and if is due to an accident, indicate the date **(month-day-year)**

8. The patient one was hospitalized by 24 hours or more**:**

☐ YES ☐ NO

From_____ To_____

(month-day-year) **(month-day-year)**

11. The loss sight is total and permanent?

☐ YES ☐ NO

C E R T I F I C A T I O N

I certify that the above information is correct, and that I am a physician, psychologist or chiropractor authorized to practice my profession, or medical guard of record. I know that the Act 139 of 1968, in Section 11 (a), provides severe penalties-such as fine, jail or both pains, to discretion of Court-by offering deception relative to a disability benefits claims.

Physician's: Signature

Date **(month-day-year)**:

Physician Print's): Name (

License number:

Local Address:

Phone: Fax:

E-mail:

B E N E F I T S

BY INCAPACITY

The Disability Benefits Act provides the payment of benefits by diseases or injuries that are not related to the work or to automobile accidents. The payments can fluctuate between $12 and $113 weekly, and extend up to 26 weeks. The disabled worker must file for these benefits during the three (3) following months at the beginning of the incapacity. If he (she) files later, indicate the reason of the delay.

BY DISMEMBERMENT

Dismemberment or total losses and permanent of the sight as a result of some compensable incapacity by this Act, the affected worker could receive between $2,000 and $4,000 of compensation. He (she) must claim these benefits not later than six (6) months since dismemberment or the loss of the sight occurred.

BY DEATH (FOR DEPENDENTS)

A death benefit of $4,000 prorated between the direct dependents of an assured worker deceased due to a compensable condition by this Act, if the death happens in the beginning in the following year of the incapacity. The dependents could also receive the benefits owed to the worker. They should file for these benefits not later than six (6) months after the worker death.

OFFICIAL USE ONLY

Application registered by		**Application reviewed by**		**Application reviewed by**	
Date		**Date**		**Date**	

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