

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 Code"): _____ 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 _____ From _____ To _____
 (month-day-year) (month-day-year) (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	<input type="checkbox"/>	<input type="checkbox"/>	\$	c. Social Security for Chauffeurs	<input type="checkbox"/>	<input type="checkbox"/>	\$
Vacation pay	<input type="checkbox"/>	<input type="checkbox"/>		Date (month -day-year)	<input type="checkbox"/>	<input type="checkbox"/>	
Date (month-day-year)	<input type="checkbox"/>	<input type="checkbox"/>		d. Social Security (Disability)*	<input type="checkbox"/>	<input type="checkbox"/>	
Sick leave	<input type="checkbox"/>	<input type="checkbox"/>		Date (month -day-year)	<input type="checkbox"/>	<input type="checkbox"/>	
Date (Month-day-year)	<input type="checkbox"/>	<input type="checkbox"/>		d. Social Security (Retirement)*	<input type="checkbox"/>	<input type="checkbox"/>	
Maternity leave	<input type="checkbox"/>	<input type="checkbox"/>		Date (Month-day-year)	<input type="checkbox"/>	<input type="checkbox"/>	
Date (month-day-year)	<input type="checkbox"/>	<input type="checkbox"/>		e. State Insurance Fund Corporation (CFSE)*	<input type="checkbox"/>	<input type="checkbox"/>	
Pension or retirement*	<input type="checkbox"/>	<input type="checkbox"/>		Date (month -day-year)	<input type="checkbox"/>	<input type="checkbox"/>	
Date (month -day-year)	<input type="checkbox"/>	<input type="checkbox"/>		f. ACAA'S Insurance	<input type="checkbox"/>	<input type="checkbox"/>	
Holidays	<input type="checkbox"/>	<input type="checkbox"/>		Date (month -day-year)	<input type="checkbox"/>	<input type="checkbox"/>	
Date (month -day-year)	<input type="checkbox"/>	<input type="checkbox"/>		g. Veterans	<input type="checkbox"/>	<input type="checkbox"/>	
Voluntary Pay	<input type="checkbox"/>	<input type="checkbox"/>		Date (month -day-year)	<input type="checkbox"/>	<input type="checkbox"/>	
Date (month -day-year)	<input type="checkbox"/>	<input type="checkbox"/>		h. A Private Plan	<input type="checkbox"/>	<input type="checkbox"/>	
b. Unemployment Insurance	<input type="checkbox"/>	<input type="checkbox"/>		Date (month -day-year)	<input type="checkbox"/>	<input type="checkbox"/>	
Date (month -day-year)	<input type="checkbox"/>	<input type="checkbox"/>		i. Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	
				Date (month -day-year)	<input type="checkbox"/>	<input type="checkbox"/>	

* 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 unemployed

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

CERTIFICACION 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 company or self-insured employer, _____, 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: _____

PART B

EMPLOYER'S REPORT

1. Worker's name: _____		2. Social Security No: _____		3. Employee's number: _____	
4. Occupation: _____		5. Weekly Salary \$ _____ monthly \$ _____		6. Regular weekly schedule _____ hours	
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 No. (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 No. 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"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <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	\$

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's 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	IS THE PLAN CONTRIBUTORY?: YES <input type="checkbox"/> NO <input type="checkbox"/>	Authorized civil employee
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PART C

MEDICAL OR PSYCHOLOGICAL CERTIFICATE

1. Patient's name:			2. Medical record number:		
3. Disability related to:	YES	NO	4. Diagnosis (Medical data that, to your knowledge, disables the patient). USE MEDICAL DIAGNOSTIC CODE). Please, specify the complications, if the incapacity is by pregnancy.		
The Job	<input type="checkbox"/>	<input type="checkbox"/>			
An automobile accident	<input type="checkbox"/>	<input type="checkbox"/>			
5. Treatment period (month-day-year) From _____ To _____			9. Dismemberment date or total or permanent loss of sight: (m/d/y)		
6. Disability period (month-day-year) From _____ To _____					
7. In case of pregnancy or abortion, indicate: (month-day-year) Expected delivery date: _____ Delivery date: _____ Abortion date: _____			10. Dismemberment cause or total and permanent loss of sight: <input type="checkbox"/> Accident <input type="checkbox"/> Disease		
8. Was the patient hospitalized for 24 hours or more?: <input type="checkbox"/> YES <input type="checkbox"/> NO From _____ To _____ (month-day-year) (month-day-year)			11. Dismemberment type, other than vision loss (specify):		

CERTIFICATION

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's Name (Print):	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 dollars 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, must 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's death.

OFFICIAL USE ONLY

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