REMITENT:

____

____

______________________ ZIP____________

EMPLOYER NAME ________________________

TRIPLE-S VIDA
PO Box 363786
San Juan, Puerto Rico 00936-3786

ATTENTION: GROUP CLAIMS DEPARTMENT
SINOT

FOLD HERE

FOLD HERE

APPLICATION FOR DISABILITY BENEFITS FOR WORKERS COVERED BY ACT 139

INSTRUCTIONS

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. The worker is responsible for the correct and prompt processing of this form, as states our SINOT Act.

Each Doctor or Chiropractor, from which you are receiving treatment, must complete Part C, MEDICAL CERTIFICATE (each one using a separate form of Part C). The Doctor of Chiropractor has to be authorized to exert his profession in Puerto Rico or the site of their residence.

TRIPLE-S VIDA

APPLICATION FOR DISABILITY BENEFITS FOR WORKERS COVERED BY ACT 139

PART A (PRINT CLEARLY) — **CLAIMANT'S REPORT**

1. Name

2. Social Security (For contribution use only)

3. Gender M ❒ F ❒

4. Residential Address

5. Postal Address

6. Date of Birth (month-day-year)

7. Occupation

8. Before becoming disabled, I worked until Date (month-day-year)

9. Email

10. Phone No.

11. 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).

a. From ____________ To _____________

b. From ____________ To _____________

c. From ____________ To _____________

12. I became disabled (Explain how, where and when your disability occurred).

Exact date of disability:
_______/_______/_______

13. Are you received SINOT benefits previously? Yes❒ No ❒
Company ____________________________________
From ___________________ To __________________

14. My disability is related to:

	YES	NO
My job	❒	❒
FSE Claim No. _____________________		
An automobile accident	❒	❒

15. During my disability I received or processed benefits of income of:

		Yes	No	Gross Amount
a.	My employer or union	❒	❒	$ ________________
	Vacation pay	❒	❒	$ ________________
	Sick leave	❒	❒	$ ________________
	Maternity leave	❒	❒	$ ________________
	Pension or retirement	❒	❒	$ ________________
	Holidays	❒	❒	$ ________________
	Voluntary pay	❒	❒	$ ________________
b.	State Insurance Fund (FSE)	❒	❒	$ ________________
c.	Social Security for Chauffeurs	❒	❒	$ ________________
d.	Social Security (Retirement)	❒	❒	$ ________________
e.	Social Security (Disability)	❒	❒	$ ________________
f.	ACAA'S Insurance	❒	❒	$ ________________
g.	Unemployment Insurance	❒	❒	$ ________________
h.	Veterans (For same disability)	❒	❒	$ ________________
i.	Private plan	❒	❒	$ ________________
j.	Others (Specify)	❒	❒	$ ________________

If the answer is "Yes", please provide copy of FSE documents, Social Security or Pension letter.
From ________________________________ To ________________________________

16. When I became disables, I was

❒ Employed ❒ Unemployed

17. I was hospitalized during 24 hours or more at (Hospital's name and address)

From _____________ To ______________

18. During my disability, I worked

From _____________ To ______________

19. If you recovered, state the date you were able to work

From _____________ To ______________

20. I returned to work on: Date (month-day-year)

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

CERTIFICATION

I certify that I am disable to work, and that all the information I submitted in this form is true. I know that Act 139, in Sections 3 (o) and 11 (a), provides severe penalties – such as fine and/or imprisonment, depending on the Court's decision – for giving false information with the purpose of receiving disability benefits.

Claimant's signature (or mark X, if unable to sign)

Date (month-day-year)

AUTHORIZATION

I authorized my employer or any other natural or legal person(s) to give to Triple-S Vida, Inc. all the information needed for the processing of my application.

Claimant's signature (or mark X, if unable to sign)

Date

Phone No.

Witness' name and address (if claimant signed with X)

Witness' signature

TRIPLE-S VIDA

APPLICATION FOR DISABILITY BENEFITS FOR WORKERS COVERED BY ACT 139

PART B (PRINT CLEARLY) — **EMPLOYER'S REPORT**

1. Name
2. Social Security **(For contribution use only)**
3. Employee No.

4. Regular weekly income $__________________
5. Regular weekly schedule ___________ Hours
6. Hire date _________/__________/_________ Month Day Year

7. Occupation ❒ Exempt ❒ No Exempt
8. Is driver's license required to job? Yes ❒ No ❒
9. The worker contributes to: Chauffeurs Insurance ❒ SINOT ❒ _______ %

10. Last day worked ______/_______/______ Month Day Year
11. Reason for unemployment: _____________________________________
Effective date:______/_______/______ Month Day Year
12. Date returned to work ______/_______/______ Month Day Year

13. Are you a voluntarily insured employer under Act 139? Yes ❒ No ❒ Group of covered employees ____________________

14. Are you covered under a private of self-insured plan, approved by the Director of the Disability Insurance Program (Act139)?

Yes ❒ No ❒ If the answer is "yes", state: Plan No. ____________________________ Insurance Co. ____________________________

15. Job-related disability: Yes ❒ No ❒
F.S.E. Claim No. ____
16. Automobile accident related disability? Yes ❒ No ❒
Accident report date: _______/_______/_______ Month Day Year

17. Have you made any payment during the worker's disability? Yes ❒ No ❒ If the answer is "Yes", complete:

TYPE OF PAYMENT	AMOUNT (Gross)	DAYS	PERIOD FROM (month-day-year)	PERIOD THROUGH (month-day-year)	DATE OF PAYMENT (month-day-year)
❒ Regular vacations leave					
❒ Sick leave					
❒ Maternity leave					
❒ Voluntary pay ❒ Gifts ❒ Wages					
❒ Pension o retirement					
❒ Holiday pay Which days?					
❒ Others (Specify)					

18. Company's name and address

Phone No: (   )

Email:

Division:

Contributions for SINOT

Worker ___________% Employer ___________%

19. Wages to worker last 4 quarters. **Please, do not include current or last quarter.**

Quarters Worked	**Year**	**Wages**
January to March	20	$
April to June	20	$
July to September	20	$
October to December	20	$

CERTIFICATION

I certify that the information I am submitting in this form is correct. I know that Act 139, in Section 11(a), provides severe penalties – such as fine and/or imprisonment, depending on the Court's decision – for giving false information in relation to a disability benefits claim.

Authorized representative signature

Occupation

Date (month-day-year)

PART C (PRINT CLEARLY) — **MEDICAL CERTIFICATE**

1. Patient's name

2. Diagnosis (Medical data that, to your knowledge, disables the patient; explain if, as a result of the illness or accident, the patient suffered amputation or dismemberment, or permanent and total loss of sight)

(PRINT CLEARLY)	USE ICD 9-CM CODE
______	______
______	______
______	______
______	______
______	______

3. Disability related to:

	YES	NO
The job	❒	❒
An automobile accident	❒	❒

4. Treatment period (be specific)

From ______ (Month-day-year) To ______ (Month-day-year)

5. Disability period (be specific)

From ______ ((Month-day-year) To ______ (Month-day-year)

6. Medical record no.

7. Patient was hospitalized during 24 hours or more? Yes ❒ No ❒

From ______ (Month-day-year) To ______ (Month-day-year)

8. In case of pregnancy or abortion, state:

Probable delivery date ______ (Month-day-year)

Delivery date ______ (Month-day-year)

Abortion date ______ (Month-day-year)

9. Surgery procedure reason, if any

Date: ______ (Month-day-year)

10. Indicate wether there was dismemberment or the permanent and total loss of sight as a result of illness or accident:

11. Observations:

CERTIFICATION

I certify that the above stated information is correct, and that I am a physician or chiropractor authorized to practice, or the custodian of medical records. I know that Act 139 of 1968, in Section 11 (a), provides severe penalties – such as fine and/or imprisonment, depending on the Court's decision – for giving false information in relation to a disability benefits claim.

Signature	Date

Physician's name (Print clearly)	Specialty	License No.

Address Email	Phone No. ( )

BENEFITS

DISABILITY

The Disability Benefits Act provides for the payment of benefits for illnesses or injuries not related to the job or to automobile accidents. Payments may range from $12 through $113 weekly, and extend up to 26 weeks. The disabled worker must file for these benefits during the tree (3) months following the beginning of disability. If he or she files later, lateness must be justified.

DISMEMBERMENT

If dismemberment of permanent and total loss of sight occurs as a result of any disability payable under this Act, the affected worker could receive compensation from $2,000 to $4,000. He or she must claim these benefits not later than six (6) months since dismemberment or loss of sight occurred.

DEATH (FOR DEPENDENTS)

A death benefit of $4,000 is payable to the direct dependents of a worker who has died due to a condition compensable under his Act, if death occurs during the year following the beginning of disability. Dependents may also receive the benefits due to the worker. They should file for these benefits not later than six (6) months after the worker's death.