TRIPLE-S VIDA

APPLICATION FOR SHORT TERM DISABILITY BENEFITS

STDI-WKDB-ADSO

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 (Please include zip code)

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

7. Occupation

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

9. I became disabled because (Explain how, where and when your disability started)

10. Before becoming disabled , my employer was:

11. 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 _____

12. My disability is related to:

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

13. When I became disabled, I was

❒ Employed ❒ Unemployed

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

From _____ To _____

15. During my disability, I worked

From _____ To _____

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

From _____ To _____

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

CERTIFICATION

I certify that I am disable to work, and that all the information I submitted in this form is true. I know Laws 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.

NOTICE

"Any person that knowingly and with the intention to defraud submits false information in an insurance application or, submits, help or make submits a fraudulent claim for a payment of a loss or any other benefit, or submits more than one claim for the same loss, hill incur in a heinous crime and hill be guilty, and sanction by each violation with a minimum penalty of five thousand ($5,000) dollars, non greater than ten thousand ($10,000) dollars or a reclusion penalty of three (3) years in a penalty of three (3) years in a permanent term, or both penalties. To intercede aggravating circumstances, the permanent established penalty can be increased up to five (5) years; if intercede lessening guilt, can be reduced to a minimum of two (2) years." Law No. 18 dated January 8th, 2004.

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)	Phone No.	Witness' signature

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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	6. Hire Date	7. Occupation
$_____	_____ Hours	_____/_____/_____ Month Day Year	❒ Exempt ❒ No Exempt

8. Last day worked	9. Reason for unemployment: _____	10. Date returned to work
_____/_____/_____ Month Day Year	Effective date:_____/_____/_____ Month Day Year	_____/_____/_____ Month Day Year

11. Job-related disability: Yes ❒ No ❒	12. Motor vehicle accident (ACAA) related accident?
F.S.E. Claim No. _____	Yes ❒ No ❒ Accident report date: _____/_____/_____ Month Day Year

13. Have you made any payment during the employee'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)					

14. Company's name and address	15. Phone No: ( )
Division/Department:	Fax No: ( )

CERTIFICATION

I certify that the information submitted in this form is correct. I read the Notice of Fraud above and understand the penalties of fraudulent claims.

NOTICE

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Authorized representative name:	Occupation
Signature:	Date (month-day-year)

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

1. Patient's name

3. Medical record number

4. Treatment period (be specific)
From _____ (Month-day-year) To _____ (Month-day-year)

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**

5. Disability period (be specific)
From _____ ((Month-day-year) To _____ (Month-day-year)

6. GAF

7. Patient was hospitalized for 24 hours or more? Yes ❒ No ❒
From _____ (Month-day-year) To _____ (Month-day-year)

8. Treatment pharmaco-therapy, other

9. In case of pregnancy or abortion, state:
Probable delivery date _____ (Month-day-year)
Delivery date _____ (Month-day-year)
Abortion date _____ (Month-day-year)

10. Disability related to:

	YES	NO
The job	❒	❒
An automobile accident	❒	❒

11. Disability caused or worsen by job:
Yes ❒ No ❒

CERTIFICATION

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NOTICE

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Signature	Date

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

Address	Phone No.
	( )