TRIPLE-S VIDA

# APPLICATION FOR DISMEMBERMENT BENEFITS

**IMPORTANT**

If dismemberment of permanent and total loss of sight occurs as a result of any disability payable under this Act 139, 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.

## PART A — CLAIMANT'S STATEMENT

| 1. Name | 2. Social Security | 3. Gender | 4. Date of birth |
|---|---|---|---|
| | | | |

| 5. Physical address | 6. Postal address |
|---|---|
| | |

| 7. Occupation | 8. Date of accident | 9. Dismemberment or permanent and total loss of sight date |
|---|---|---|
| | | |

| 10. Lesion related to: | 11. I was hospitalized during 24 hours or more at (Hospital's name and address) | 12. Explain how, where and when your dismemberment occurred. |
|---|---|---|
| Yes No<br>The job? ❒ ❒<br>An automobile accident? ❒ ❒ | From _____ (Month-day-year) To _____ (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 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 |
|---|---|
| | |

**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.

| Date | Claimant's signature | Phone No. |
|---|---|---|
| | | |

| Witness' name and address of (if claimant sign with X) | Witness' Signature |
|---|---|
| | |

## PART B — EMPLOYER'S STATEMENT

| 1. Name | 2. Social Security | 3. Employee number |
|---|---|---|
| | | |

| 4. Occupation | 5. Weekly income | 6. Regular weekly schedule | 7. Is driver's licence required to job? |
|---|---|---|---|
| | $ _____ | _____ hours | Yes ❑ No ❑ |

| 8. The worker contributes to: | 9. Last date worked | 10. Reason for unemployment: _____ |
|---|---|---|
| Chauffeurs insurance ❑ SINOT ❑ | _____/_____/_____ (Month-day-year) | Effective date: _____/_____/_____ (Month-day-year) |

| 11. Lesion related to the job: | 12. Lesion related to an automobile accident: |
|---|---|
| Yes ❑ Date of accident _____<br>No ❑ F.S.E. claim number _____ | Yes ❑ No ❑ |

**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.

Company's name and address

| Authorized representative signature | Phone no.: | Date |
|---|---|---|
| | ( ) - | |

TRIPLE-S VIDA

APPLICATION FOR DISABILITY BENEFITS FOR WORKERS COVERED BY ACT 139

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

1. Patient's name

2. Diagnosis and concurrent conditions (Please indicate wether as a result of an illness or accident, the patient suffered a dismemberment, or permanent and total loss of sight)

| (PRINT CLEARLY) | USE ICD 9-CM CODE |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

3. Lesion related to:

| | YES | NO |
|---|---|---|
| The job | ❒ | ❒ |
| An automobile accident | ❒ | ❒ |

4. If the amputation or dismemberment, or the permanent and total loss of sight was caused by an **accident**, please indicate the date:

_____/_____/_____
(Month-day-year)

5. If the amputation or dismemberment, or the permanent and total loss of sight was caused by an **illness**, please indicate the sickness start date:

_____/_____/_____
(Month-day-year)

6. Medical record no.

7. Date of first treatment:

_____/_____/_____
(Month-day-year)

8. Dismemberment or permanent and total loss of sight date:

_____/_____/_____
(Month-day-year)

9. Visual impairment:

a. How was the eye vision on the patient's evaluation?

With glasses O.D. ____ O.S. ____ ____/____/____
(Month-day-year)

Without glasses O.D. ____ O.S. ____ ____/____/____
(Month-day-year)

b. Date when the visual correction was reduce irretrievably to 20/200 or less, on the eye with better vision:

O.D. ❒ O.S. ❒ _____/_____/_____
(Month-day-year)

c. The vision can be fully restored totally or partially with:

❒ O.D. glasses ❒ Treatment ❒ Surgery ❒ Non-recoverable

❒ O.S. glasses ❒ Treatment ❒ Surgery ❒ Non-recoverable

d. The patient is considered:

❒ Total and Legally blind ❒ O.D. ❒ O.S.

❒ Partially blind ❒ O.D. ❒ O.S.

10. The loss consists of:

❒ Both feet, from or above the ankle

❒ Both arms, from or above the wrist

❒ One arm and one leg

❒ One arm, from or above the wrist

❒ One leg, from or above the ankle

❒ One hand or one foot

❒ At least three (3) fingers of the hand or toes **(please fill #9)**

❒ Eye sight from one eye – legally blind permanently **(please fill #9)**

10. 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 | Phone No. |
|---|---|
| | ( ) |