TRIPLE-S VIDA

APPLICATION FOR EXTENSION OF DISABILITY BENEFITS

Name and address of claimant

SINT-_____
Claim number

_____
Social Security number
(For contribution use only)

INSTRUCTIONS

This form must be completed ONLY if still disabled after the date assigned by the benefits. This application is only an extension and does not replace the initial Application for Disability Benefits for Workers Covered by Act 139. The information provided should be clear and precise. This form must be submitted within three (3) months from the disability date.

PART A — CLAIMANT STATEMENT

1. Occupation

2. Is driver's license required to job?
Yes ❒ No ❒ License number: _____

3. Are you recovered? If the answer is "Yes", state the date:	Month	Day	Year
Yes❒ No ❒			

4. Do you returned to work? If the answer is "Yes", state the date:	Month	Day	Year
Yes ❒ No ❒			

5. In my opinion, my disability is related to:
My job Yes❒ No ❒
FSE claim number: _____
An automobile accident Yes❒ No ❒

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

7. During my disability I received or processed benefits of income of (Do not include our benefits):

	YES	NO	Amount		YES	NO	Amount
a. My employer or union	❒	❒	$ _____	c. Social Security for Chauffeurs	❒	❒	$ _____
Regular Vacations Leave	❒	❒	$ _____	d. Social Security (Retirement)	❒	❒	$ _____
Sick Leave	❒	❒	$ _____	e. Social Security (Disability)	❒	❒	$ _____
Maternity Leave	❒	❒	$ _____	f. ACAA's Insurance	❒	❒	$ _____
Pension or Retirement	❒	❒	$ _____	g. Unemployment Insurance	❒	❒	$ _____
Holidays Who?	❒	❒	$ _____	h. Veterans (For same disability)	❒	❒	$ _____
Voluntary Payment	❒	❒	$ _____	i. Private plan	❒	❒	$ _____
b. State Insurance Fund (FSE)	❒	❒	$ _____	j. Other (Specify) _____	❒	❒	$ _____

If the answer is "Yes", please state the date: From _____ To_____

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 of June 26, 1968, 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.

8. Date (Month-Day-Year)	9. Claimant signature	10. Phone number
		( ) -

IMPORTANT

This certificate must be completed by Benefits or Human Resources authorized representative of your company.

PART B		EMPLOYER STATEMENT
1. Employee name	2. Social Security number (For contribution use only)	3. Employee number:

4. Does the claimant worked after the date you assigned benefits? Yes ❒ No ❒ If the answer is "Yes", state the date: From:_____ (Month-Day-Year) To: _____ (Month-Day-Year)	5. Does the claimant returned to work? Yes ❒ No ❒ If the answer is "Yes", state the date:	Month	Day	Year
	6. Regular Weekly Income $ _____	7. Regular Weekly Schedule _____		

8. Have you made any payment during the worker's disability? Yes ❒ No ❒ If the answer is "Yes", complete:	Amount (Gross)	Days	Period From (Month-Day-Year)	Period To (Month-Day-Year)	Date of Payment (Month-Day-Year)
❒ Regular Vacations Leave					
❒ Sick Leave					
❒ Maternity Leave					
❒ Voluntary Payment ❒ Gift ❒ Wages					
❒ Pension or Retirement					
❒ Holidays Who?					
❒ Other (Specify)					

CERTIFICATION

I certify that the information I am submitting in this form is correct. I know that Act 139 of June 26, 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.

9. Employer name	10. Authorized representative signature
11. Postal address Phone number: ( ) -	12. Occupation
	13. Date (Month-Day-Year)

PO BOX 363786
SAN JUAN PR 00936-3786
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Fax: (787) 625-8556
www.sssvida.com

TRIPLE-S VIDA

APPLICATION FOR EXTENSION OF DISABILITY BENEFITS

IMPORTANT

This certificate must be completed by a physician, chiropractor or psychologist licensed to practice in Puerto Rico or the claimant's residence or in their absence, the custodian of medical records.

PART C				**PHYSICIAN STATEMENT**			
1. Patient name				2. Record number			
3. Diagnosis **USE ICD 9-CM CODE.** (If the disability is for pregnancy, specify the complications.) **Please print**							
4. The patient has been treated	Month	Day	Year	4. The patient is or was unable to work	Month	Day	Year
From				From			
To				To			
6. Date of hospitalization, if any Hospital:	Month	Day	Year	7. In your opinion, the disability is related to:			
From					Yes	No	
To				The job	❒	❒	
				An automobile accident	❒	❒	
8. In case of pregnancy or abortion indicate:	Month	Day	Year	10. If you have not been recovered, indicate the probable date of recovery.	Month	Day	Year
Probable delivery date							
Delivery date				11. Date of last review	Month	Day	Year
Abortion date							

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 June 26, 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.

12. Physician name (Please print)	13. Licence number	14. Specialty
15. Address Phone number: ( ) -	16. Signature 17. Date (Moth-Day-Year)	

Please send this form to the following address:

TRIPLE-S VIDA, INC
GROUP CLAIMS DEPARTMENT
PO BOX 363786
SAN JUAN PR 00936-3786