Desde 1960

COSVI

COOPERATIVA DE SEGUROS DE VIDA DE PUERTO RICO

INSTRUCTIONS TO COMPLETE THE APPLICATION FOR BENEFITS
****IMPORTANT****

IN OUR EFFORT TO SERVE YOU BETTER, WE INCLUDE THE LIST OF DOCUMENTS THAT MUST BE SUBMITTED WITH THE APPLICATION FOR BENEFITS. THE COOPERATIVA DE SEGUROS DE VIDA DE PUERTO RICO, COSVI, RESERVES THE RIGHT TO REQUEST ADDITIONAL INFORMATION IF NECESSARY TO COMPLETE THE ANALYSIS OF YOUR CASE. REMEMBER IT IS NECESSARY TO INCLUDE THE POLICY NUMBERS FOR WHICH YOU ARE MAKING THE CLAIM.

Benefit requested under the policy of:	Required Documents:
Cancer or Pernicious Diseases	☑ Pathological Report or Diagnostic Tests ☑ Bills or receipts of incurred expenses.
Accidental Death and Dismemberment with Compensation Benefit for Hospitalization due to Accident and Benefit for adequate use of Safety Belt	☐ Autopsy Protocol (in case of death) ☐ Death Certificate indicating cause of death_____ ☐ Discharge Summary indicating dates of hospitalization and discharge ☐ Police Report ☐ Toxicology Report and/or driver's alcohol test
Endorsement for Convalescing at Home due to Accident	☐ Medical Certificate indicating the convalescing period at home, after hospitalization due to an accident
Endorsement for Medical Treatment in the Emergency Room	☐ Emergency Room Report ☐ Bill indicating incurred expenses paid by the insured (Expense Deductible)
Compensation for Hospitalization in the Intensive Care Unit	☐ Intensive Care Unit certification indicating date and time of admission and discharge, Including diagnosis
Endorsement for Disability due to Accident or Disease	☐ Medical Certificate indicating disability period and diagnosis ☐ In work-related case, submit Medical Certificate (forma 1021 CFSE) ☐ If self-employed, submit copy of certified Income Tax Return ☐ Medical evidence
Endorsement for Organ Transplant	☐ Bills or receipts of expenses incurred ☐ Medical evidence
Endorsement of Optional Accident Benefits	☐ Burn – Medical evidence specifying the degree of the burn and Emergency Room Report ☐ Fracture and Dislocation – X-Ray Report and Emergency Room Report ☐ Lacerations – Notes for wound procedures and Emergency Room Report ☐ Mutilations – Medical evidence and Emergency Room Report
Endorsement Heart Attack, Stroke, Coma and first-time Paralysis	☐ Medical evidence
Endorsement of Education for children and spouses	☐ Study certificate from accredited educational institution ☐ Death Certificate with cause of death ☐ Birth Certificates of children ☐ Copy of medical record in case of dismemberment
Compensation for Hospitalization (Sickness or Injury)	☐ Discharge Summary indicating hospitalization and discharge dates
Endorsement Max Woman	☐ Pathological Report ☐ Expenses bill ☐ Discharge Summary ☐ Surgery Report

In case the claim is for an Eligible Dependent, it must include:

Spouse	• Marriage Certificate
Single children not older than 21 years or up to 23 years*	• Birth Certificate (*Certification of Studies)
Stepchild	• Certificate of Custody

WE WANT TO PROCESS YOUR CLAIM PROMPTLY AND RAPIDLY. TO ACHIEVE THIS IT IS NECESSARY THAT THE APPLICATION FOR BENEFITS BE TOTALLY COMPLETE, THE ORIGINAL DOCUMENT AND SIGNED BY THE CLAIMANT. REMEMBER TO SUBMIT THE INDICATED INFORMATION AND DOCUMENTS AS REQUIRED. THAT WAY UNNECESSARY DELAYS IN THE CLAIM PROCESS CAN BE AVOIDED.

Send your Application for Benefits to the following address: :

COOPERATIVA DE SEGUROS DE VIDADE PUERTORICO, COSVI
PO BOX 366267 SAN JUAN PR00936-6267
OR TO FAX: 787-200-2574

IF YOU HAVE ANY QUESTIONS ABOUT FILING YOUR APPLICATION FOR BENEFITS PLEASE CONTACT OUR

CUSTOMER SERVICE CENTER: 787-751-2828

Desde 1960
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COOPERATIVA DE SEGUROS DE VIDA DE PUERTO RICO

APPLICATION FOR BENEFITS FOR MASS MARKETING POLICIES

☐ **INSURED** ☐ **SPOUSE** ☐ **DEPENDENT** ☐ **RELATIONSHIP WITH PRIMARY INSURED**

☐ **INDICATE THE POLICY(IES) FOR WHICH YOU CLAIM BENEFITS:** **POLICY NO.**

☐ CANCER (*) ☐ PERNICIOUS DISEASES(*) ☐ DISABILITY ☐ ORGAN TRANSPLANT **23-**_____

☐ OPTIONALS ACC. ☐ EDUCATIONAL ☐ MAX WOMAN

☐ **ACCIDENTAL DEATH, DISMEMBERMENT, COMPENSATION FOR HOSPITALIZATION FOR ACCIDENT (**)** **26-**_____

☐ DEATH ☐ DISMEMBERMENT ☐ COMPENSATION ☐ EMERGENCY ROOM ☐ DISABILITY

☐ ENDORSEMENT HEART ATTACK & OTHERS ☐ OPTIONAL ACC. ☐ EDUCATIONAL ☐ MAX WOMAN

☐ **COMPENSATION FOR HOSPITALIZATION (**) (HOSPIPAGO)** ☐ **ORGAN TRANSPLANT** **26-**_____

☐ **COMPENSATION FOR HOSPITALIZATION IN INTENSIVE CARE UNIT (**)** **25-**_____

PAYEE INFORMATION

Name_____ **Payee's Social Security**_____
(Last Name) (Mother's Maiden Name) (Name)

Home Address _____

Postal Address _____

Email _____

CLAIMANT INFORMATION

Name_____ **Payee's Social Security**_____
(Last Name) (Mother's Maiden Name) (Name)

Occupation _____ Date of Birth _____
Month Day Year

Telephone(s) _____ Email _____

DESCRIPTION OF THE CONDITION

If this is an accident, describe in detail **How, When and Where it occurred**_____

_____

_____

In the event of a disease, indicate: **When did the first symptoms appear:** Month_____ Day_____ Year_____

Date you were treated for the first time: Month_____ Day_____ Year_____

Indicate the name and address of every doctor and hospital where you have been treated in the last two years. **Indicate your primary doctor.**

1. _____ 2. _____ 3. _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you been diagnosed Cancer or any Pernicious Disease previously? ☐ YES ☐ NO

If yes, indicate the **date of the diagnosis.** Month_____ Day_____ Year_____

(*) INCLUDE THE FIRST BIOPSY OF THE POSITIVE DIAGNOSIS OR TESTS OF THE PERNICIOUS DISEASE DIAGNOSIS

(**) YOU MUST INCLUDE COPY OF THE DISCHARGE SUMMARY FOR THE CLAIM PERIOD

(IN CASE OF ACCIDENTAL DEATH, OMIT THIS PART)

1. Patient's Name _____ 2. Age_____
(Last Name) (Mother's Maiden Name) (Name)

3. Primary Diagnosis_____ ICD-9 CODE:_____ Month_____Day_____Year _____

4. Secondary Diagnosis_____ICD-9 CODE:_____ Month_____Day_____Year _____

5. Were there any complications? Explain_____

_____

6. In case of maternity, indicate date the pregnancy began. Month_____Day_____Year _____

7. If this is an injury, describe how and when it occurred._____

_____

8. In case of illness, indicate:

a) When did the first symptoms appear: Month_____Day_____Year _____

b) Date first attended: Month_____Day_____Year _____

c) Date of last treatment or medical visit: Month_____Day_____Year _____

9. Has the claimant suffered this or similar condition previously? ☐ Yes ☐ No

a) If yes, indicate: Diagnosis or condition_____ICD-9_____

b) Date the condition appeared: Month_____Day_____Year _____

10. Was the claimant hospitalized for the condition being certified? ☐ Yes ☐ No If yes, indicate:

Name and address of hospital _____

_____

Period of hospitalization: From_____ To_____

11. Was patient hospitalized in the Intensive Care Unit? ☐ Yes ☐ No From_____To_____

MEDICAL CERTIFICATION

I certify that the indicated condition, in my opinion, truly describes the patient's medical situation. Similarly, I CERTIFY that I am a physician authorized to practice the profession.

Name of Physician _____ Specialty _____

Address _____ License No. _____

_____ Social Security Number _____

_____ Signature _____

Telephone _____ Date _____

Email _____

IN CASE OF BENEFIT CLAIM DUE TO DISABILITY
MEDICAL REPORT

1. Name_____ 2. Social Security No. _____

3. a. Patient has been disabled: From_____To_____

b. I attended this patient for his present condition: From_____To_____

4. Diagnosis of cause of disability_____ ICD-9-CM_____

5. Is the disability of claimant related to her pregnancy? ☐ Yes ☐ No
Date of childbirth_____ Probable date of childbirth_____

6. Is patient able to return to work? ☐ Yes ☐ No

7. Date of recuperation or approximate date of recuperation: Month_____ Day_____ Year_____

8. Is disability of claimant related to his/her work? ☐ Yes ☐ No

9. If this disability has lasted longer than expected, indicate the reason

10. Indicate the Labs and X-Rays performed on the patient.

_____ _____
PRINTED NAME AND ADDRESS OF PHYSICIAN PHYSICIAN'S SIGNATURE

Telephone_____ License No._____ Date_____ Social Security No._____

EMPLOYER DECLARATION

1. Name_____Social Security No._____ Employee No._____
Last Name Mother's Maiden Name Name

2 Last day the INSURED physically was present at his job.
Month _____ Day_____Year_____

3. Date the INSURED physically returned to his job.
Month _____ Day_____Year_____

4. Type of Work: ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy

ANSWER QUESTION NO. 5 IF IT APPLIES TO THE INSURED; OTHERWISE, GO TO QUESTION NO. 6
PLEASE, DO NOT ANSWER BOTH QUESTIONS, ONLY THE ONE THAT APPLIES.

5. Salaried employee who was receiving a fixed salary at the date of disability being claimed:

☐ WEEKLY Gross Salary $_____ ☐ BIWEEKLY Gross Salary $_____ ☐ MONTHLY Gross Salary $_____ ☐ ANNUAL Gross Salary $_____

6. Employee who earns a per-hour daily wage:
a. $_____ per hour b. Number of hours expected to work a week_____.

7. Is this employee claiming or receiving benefits under the Work Accident Compensation Act for this disability?
☐ Yes ☐ No If yes, indicate the number of the case:_____

8. How long what been working for you at the time of the disability?

9. Is he still employed by you? ☐ Yes ☐ No If no, indicate the date the employee resigned or was terminated from his job.
Month _____ Day_____Year_____

10. Is this employee receiving Social Security benefits? ☐ Yes ☐ No If yes, indicate Month _____ Day_____Year_____

EMPLOYER_____ ADDRESS_____

DATE Month _____ Day_____Year_____ _____

NAME AND TITLE_____ EMAIL _____

TELEPHONE_____EXTENSION_____ SIGNATURE_____

CERTIFICATE AND AUTHORIZATION TO SUBMIT MEDICAL AND EMPLOYMENT INFORMATION

I, _____, of legal age, _____, resident of

_____, Puerto Rico, _____.

(Family relation with the patient or deceased)

Hereby authorize all hospital institution and every physician who has been consulted by the undersigner or the deceased, in whose possession there is some type of medical record of the undersigner, to render a copy and/or a summary of such record to Cooperativa de Seguros de Vida de Puerto Rico, COSVI, or its Authorized Representative bearer of the original document or a photocopy of it.

Similarly, I authorize the creditor to deliver copy of all existing documentation of the debt claimed in this application. In addition, I authorize any person, public or private society or corporation for which I have worked to submit to Cooperativa de Seguros de Vida de Puerto Rico, COSVI, or its Authorized Representative bearer of the original document or a photocopy of it all the information related to me and my work as may be requested, including, but not limited to, employment certifications, medical certifications, HIV tests or AIDS history, synopsis of my employment file, days worked, periods of absence for sickness, salaries, worked I performed, date in which I performed for the last time the tasks of my job and the reasons for leaving my employment.

I hereby renounce to any disposition of law that might prohibit or limit the disclosure of the information hereby authorized as well as I hold harmless each of the hospital institutions, physicians, people or entities for which I have worked for submitting to Cooperativa de Seguros de Vida de Puerto Rico, COSVI, or the holder of this authorization, copy of any information of the undersigned they have in their possession, for delivering or preparing any document related to such information.

Similarly, I accept that the aforementioned information may be submitted with the presentation of a photocopy of this authorization, accepting equally that said copy will be as valid as its original.

Cooperativa de Seguros de Vida de Puerto Rico, COSVI, in compliance with the specifications of Law under which the Insurance Enterprises are regulated, expresses, for your knowledge and compliance, the following:

"Any person who knowingly and with the intention of defrauding submits false information in an Insurance Application or, who files or facilitates to file a fraudulent claim for payment of a loss or other benefit, or files more than one claim for the same damage or loss, is committing a felony and if convicted, shall be sanctioned, for each violation with a penalty of a fine no less than five thousand (5,000) dollars, but no higher than ten thousand (10,000) dollars or a fixed-term imprisonment of three (3) years, or both penalties. If there are aggravating circumstances, the fixed penalty may be increased up to a maximum of five (5) years; if attenuating circumstances are present, it may be reduced up to a minimum of two (2) years.

In testimony of which, I sign the present in_____, Puerto Rico on _____

_____, 20_____.

_____ _____ _____

Printed name Date Signature