APPLICATION FOR BENEFITS COOP INSURANCE
LIFE AND DISABILITY

COVERAGE (INDICATE): ☐ DISABILITY ☑ DEATH ☐ INVOLUNTARY UNEMPLOYMENT

	PÓLICY		POLICY
☐ PERSONAL LOAN PLUS	02-_____	☑ **FUNERAL**	**20-_5156_____**
☐ SHARES AND SAVINGS	03-_____	☐ LOAN WITHOUT PREX	22-_____
☐ SPONSORSHIPS AND SAVINGS	04-_____	☐ CREDIT CARD	83-_____
☐ CERTIFICATE OF DEPOSIT	05-_____	☐ CREDIT LINE	84-_____
☐ AUTO	07-_____	☐ MORTGAGE LOANS	96-_____
☐ DIRECTORS INSURANCE	08-_____	☐ TOTAL DISABILITY	97-_____

I. INSURED INFORMATION

1. LAST NAME	**MOTHER'S MAIDEN NAME**	**FIRST NAME**	**2. SOCIAL SECURITY**

3. Residential Address (Street/Urb./City)	4. Postal Address & Zip Code	5. Date of Birth

6. Occupation	7. Telephone Residential: Office:	8. Name & Address of Employer

9. Date you began to work	10. Last date of work
Month _____ Day _____ Year _____	Month _____ Day _____ Year _____

11. Reason for leaving work

12. Illnesses the Insured had at the time of Disability of Death

13. Name and Address of Physicians and / or Hospitals that cared for the Insured	14. Medical Record
a) _____ _____ b) _____ _____	a) _____ b) _____

15. Name and Address of Medical Plan	16. Contract No.

17. Check if the Insured is receiving or trying to receive benefits from any of the following institutions:

	Yes	No	Month Day Year	Location
U.S. Social Security (for disability)	☐	☐	_____	_____
U.S. Social Security (for age)	☐	☐	_____	_____
State Insurance Fund Office _____ Case number _____	☐	☐	_____	_____
SINOT Specify: _____	☐	☐	_____	_____

If you have evidence or the decision from the Social Security specifying the conditions evaluated and the years established for the revision of the case or of any of the other previously mentioned institutions, please include them with the benefits claim. This will help to speed up your case.

II. REPORT FROM THE POLICY HOLDER (COOPERATIVA)

1. NAME OF POLICY HOLDER	2. MEMBER NO.	3. Date the member joined the Cooperativa: Month _____ Day _____ Year _____

III. BENEFITS FROM LOAN INSURANCE (DOES NOT APPLY IN FUNERAL OF DIRECTOR OR SPONSORSHIPS

The insured debtor obtained the following loans from this Cooperativa (including Credit Line and Credit Card):

Amount	Date the loan was granted Month Day Year	Number of Installments	Pending Balance (excluding interests)
1.			
2.			
3.			
4.			
5.			

Are any of these loans in an agreement to pay? ☐ Yes (include agreement to pay) ☐ No

IV. SAVINGS AND SPONSORSHIP INSURANCE BENEFITS

1. Amount of Shares $_____
2. Amount of Deposits $_____
3. Amount of Sponsorships $_____
4. Amount of Christmas Club $_____
5. Certificate of Deposit $_____
6. Other Insured Deposits $_____

CERTIFICATION

I certify that_____ is a debtor and depositor of this Cooperativa and that what is claimed are the balance due and the savings deposited as of the date of disability or death.

Printed name of Authorized Person JOSE A. CRUZ VÉLEZ

Address

COOP. A/C RAFAEL CARRION, JR. PO BOX 362708 SAN JUAN, PR 00936-2708

Telephone (787) 977-2202 /(787) 723-0077 Ext. 3003

Email jose.cruz@popular.com

_____
Signature of Person Authorized by the Cooperativa to provide this information

Date _____

CERTIFICATION AND AUTHORIZATION TO PROVIDE MEDICAL AND WORK

I _____ , of legal age, _____, resident

of _____ Puerto Rico, as _____ _____

City, State | Relation with the Deceased | Address

Hereby authorize all hospital institution and all medical faculty member who had been consulted by the signer or deceased or in whose possession there is any type of medical record of the undersigned to hand in copy of it and/or a summary of it to the **Cooperativa de Seguros de Vida de Puerto Rico**, **COSVI**, or to the bearer of this document or copy thereof.

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 to the bearer of this statement or photocopy of all the information related to me and my work as may be required, including, but not limited to, employment certifications , medical certifications, HIV tests or AIDS history, a synopsis of my employment file, days worked, periods of absence for sickness, salaries, work I performed, date on which I performed 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 about 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, states, 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 _____ on _____ .
City, State | Date

Claimant's address _____

Telephone _____ Email address _____

_____
Signature