APPLICATION OF BENEFIT

Full Name of Patient (Print) **Age** **Social Security**

Address **No.** **Street** **City** **State** **Zip Code**

Occupation **Civil Status** **Sex** **Height** **Weight**

Cooperativa de Ahorro y Crédito Rafael Carrión, Jr. P .O. Box 362708 San Juan, PR 00936-2708

Name and Address of Policyholder or Group Insured

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

The patient is responsible for the completion of this form without expenses to the Company. Include a photocopy of all your medical records. The doctor that complements this certification should include a photocopy of all the patient's records. This certification will not be valid if photocopy is not send.

A. Diagnosis that causes disability _____

For this disability, when first symptoms or accident occurred Month _____ Day _____ 20 ____

Has patient ever had same, similar predisposing condition or any risk factor? ☐ YES ☐ NO

Explain: _____

_____

B. Mayor Physical Findings _____

C. Mayor Laboratory/Pathological Findings _____

D. Mayor Diagnostic Imaging Findings _____

E. List of Medications and Therapy: _____

_____

F. Frequency of Hospitalizations ☐ Weekly ☐ Monthly

Explain: _____

G. When Did you hospitalized the patient?

First: Month ____ Day ____ 20 ____

Last: Month ____ Day ____ 20 ____

PROGNOSIS (Uncertain or guarded are not acceptable classification) (Only one choice)

A) Functional: ☐ Good ☐ Poor

B) Vital: ☐ Good ☐ Poor

OPINION OF DISABILITY

I consider this patient as having a: (only one choice)

☐ Permanent & Total Disability

☐ Temporary & Total Disability

☐ Temporary & Total Disability

☐ Permanent & Total Disability

☐ No Disability

IF DISABILITY IS PERMANENT & TOTAL

A. On what date patient became totally & permanently (continuously) disabled? Month _____ Day ____ 20 ____

B. This disability impairs the patient to: (Only one choice)

☐ Perform the duties of any gainful occupation or employment

☐ Perform just the duties of his/her present occupation duties he/she, can do _____

_____

_____

C. Is patient a suitable candidate for rehabilitation program? ☐ YES ☐ NO

D. Briefly justify your medical disability opinion: _____

_____

_____

INCLUDE A PHOTOCOPY OF ALL YOUR MEDICA RECORDS. The doctor that complements this certification should include photocopy of all the patient's records. This certification will not be valid if photocopy is not send.

E. Name & Address of any doctor that you have rendered medical treatment in reference to said disability

_____

I hereby certify that the given information regarding _____

_____ , is accurately described.

Name Dr. _____ Signature _____

(Printed)

Address _____

City & State _____

Medical State License _____ Date of this report _____

☐ GP or ☐ FP _____ Specialty _____

Telephone: _____