COOPERATIVA DE SEGUROS DE VIDA DE PUERTO RICO
PO BOX 366267
SAN JUAN, PUERTO RICO 00936-6267
TELEPHONE: (787) 751-5656
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APPLICATION FOR BENEFITS – GROUP LIFE INSURANCE

INSTRUCTIONS

AT THE TIME OF THE FILING, make certain to include the required documents for the Application for Benefits being claimed. Fill out all blanks; leaving any blank unanswered may delay the decision on your claim.

HOW TO FILL OUT THIS APPLICATION

FIRST: Fill out all blanks of the Insured's report and the certification and authorization for medical and work information.

SECOND: For disability claims, the medical certificate must be filled out by your physician, who must be authorized to practice his profession in Puerto Rico, or in his stead, by the custodian of the medical records. If you have been under treatment with more than one physician, provide evidence from each physician, separately. The physician must include complete copy of your medical record.

THIRD: Applications with N/A in spaces that correspond to medical evidence or information needed to determine the degree of disability will not be accepted.

THE FOLLOWING DOCUMENTS MUST BE INCLUDED WITH THE APPLICATION

IN CASES OF DEATH

1. Birth Certificate of the Deceased Person
2. Death Certificate
3. In cases of accidental death, Police Report and Autopsy Protocol
4. Copy of a photo id of claimant

IN FUNERAL INSURANCE CASES

Birth Certificate of the Deceased Person
2. Death Certificate
3. Marriage Certificate if the spouse in the Family Plan dies
4. Copy of photo id of claimant

IN DISABILITY CASES

1. Birth Certificate
2. All evidence in your possession
3. Names and addresses of all physicians who have treated you
4. Medical Certificate (APS)
5. In cases of an accident, loss of sight or dismemberment, include the Police Report
6. Copy of photo id of claimant

APPLICATION FOR BENEFITS - GROUP LIFE INSURANCE

INSTRUCTIONS

☐ DEATH ☐ PRIMIUM PAYMENT WAIVER ☐ DISMEMBERMET OR LOSS OF SIGHT

☐ FUNERAL ☐ DISABILITY

I. INFORMATION ABOUT INSURED PERSON

1. POLICY NO.	2. FATHER'S SURNAME MOTHER'S MAIDEN NAME NAME	3. SOCIAL SECURITY
4. DEACEASE DEPENDENT'S (FUNERAL FAMILY PLAN)	5. DECESEAD DEPENDANT'S SOCIAL SECURITY NO.	
6. HOME ADDRESS	7. MAILING ADDRESS	8. DATE OF BIRTH Month_____Day_____Year_____
9. Occupation	10. Date of Hire Month_____Day_____Year_____	11. Name and Address of Employer
12. Last day of work Month_____Day_____Year_____	13. Reason for ceasing to work	
14. Illnesses the Insured person had at the time of disability or death		
15. Names and Addresses of Physicians and/or Hospital that treated the Insured, and medical record numbers.		
16. Health Insurance Plan and address	17. Contract Number	

II. INDICATE IF YOU ARE RECEIVING OR APPLYING FOR BENEFITS FROM ANY OF THE FOLLOWING INSTITUTIONS

	YES	NO	FROM Month	Day	Year	LOCATION
Social Security (Disability)	☐	☐	_____	_____	_____	_____
Social Security (Age)	☐	☐	_____	_____	_____	_____
State Insurance Fund _____	☐	☐	_____	_____	_____	_____
Non-Occupational Short-Term Disability Insurance (SINOT) Specify_____	☐	☐	_____	_____	_____	_____

Submit evidence for the decision of the Social Security or any of the institutions previously mentioned.

CERTIFICATION AND AUTHORIZATION TO SUBMIT MEDICAL AND WORK INFORMATION

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

_____, as _____,
State the Insured or Relationship with Deceased Person

hereby authorize all hospital institutions and all medical personnel who may have been consulted by the undersigned or deceased person, or in whose possession there is any medical record of the undersigned, to submit a copy of said record and/or summary of it to the **Cooperativa de Seguros de Vida de Puerto Rico, COSVI**, or the bearer of this document or of a copy of it.

Likewise, I authorize the creditor to submit a copy of all existing documentation of the debt claimed in this application. In addition, I authorize any person, partnership or public or private corporation with which I may have worked to submit to the **Cooperativa de Seguros de Vida de Puerto Rico, COSVI**, or the bearer of this declaration or copy of it, all claims related with the undersigned or deceased person or his/her work as requested, including, but not limited to, employer's certifications, medical certifications, HIV tests or AIDS history, synopsis of my employee file, days worked, periods of absence due to illnesses, salaries, work functions, date when I last performed the tasks of my work and the reasons for ceasing to work.

By this means I renounce to all dispositions of law that could prohibit or limit the revelation of the information herein authorized, as well as I hold harmless each of the hospital institutions, medical personnel or entities for which I may have worked, for submitting to the **Cooperativa de Seguros de Vida de Puerto Rico, COSVI,** or the holder of this authorization, copy of any information they may have about the undersigned, or for providing a summary or preparing any document related to such information.

In addition, I accept that said information may be submitted with the presentation of a photocopy of this authorization, equally admitting that such copy is as valid as its original.

The **Cooperativa de Seguros de Vida de Puerto Rico, COSVI**, in compliance with the specifications of law that regulates the Insurance Companies, states for your information and compliance the following:

"Any person who knowingly and with the intention to defraud presents false information in an insurance application or who submits, helps to submit or makes someone else submit a fraudulent claim for the payment of a loss or other benefit, or who submits more than one claim for the same damage or loss, shall incur in a felony and, if convicted, shall be sanctioned, for each violation with a penalty of a fine no smaller than five thousand (5,000) dollars nor to exceed ten thousand (10,000) dollars, or a fixed reclusion term of three (3) years, or both penalties. If aggravating circumstances are involved, the maximum penalty may be increase up to a maximum of five (5) years; if extenuating circumstances are involved, it could be reduced up to a minimum of two (2) years."

In testimony thereof, I sign the present document in _____, _____, on _____, 2007.

_____
Signature

Telephone: _____ _____
Work Home

TO BE COMPLETED BY THE POLICY HOLDER

Name of Policyholder _____ Policy No. _____

Employee Name _____

Last day of work Month ____ Day ____ Year _____

Date employment commenced Month ____ Day ____ Year _____

Date of entry for the Insurance Month ____ Day ____ Year _____

Address _____Telephone _____

CERTIFICATION

I hereby certificate that _____ was of the insured group at the date of the loss.

Name of the authorized official _____

_____ _____
Signature of authorized official Date