PART A **CLAIMANT´S REPORT**

1. Name (Last name, and/or husband, and first name) (PRINT LETTER)	2. Social Security Number **(For contribution use only)**	3. Sex [ ] M [ ] F
4. Postal address (Include "Zip Code"):	5. Residential address: Phone_____	

6. Date of birth (month-day-year)	7. Occupation:	8. Before becoming disabled, I worked until: Date (month-day-year)

9. My employers during the last 18 months were [State the companies´ names and addresses, dates of employment, and if you worked at the same time for more than one employer (Part B) for each one.]

a)	b)
From_____ (month-day-year) To_____ (month-day-year)	From_____ (month-day-year) To_____ (month-day-year)

10. During my disability: ☐ I received ☐ I am receiving ☐ I am managing benefits or income of:

	YES	NO	GROSS AMOUNT		YES	NO	GROSS AMOUNT
a. My employer or union	☐	☐	$	c. Social Security for Chauffeurs Date (month -day-year)	☐	☐	$
Vacation pay Date (month-day-year)	☐	☐		d. Social Security (Disability)* Date (month -day-year)	☐	☐	
Sick leave Date (Month-day-year)	☐	☐		d. Social Security (Retirement)* Date (Month-day-year)	☐	☐	
Maternity leave Date (month-day-year)	☐	☐		e. State Insurance Fund Corporation (CFSE)* Date (month -day-year)	☐	☐	
Pension o retirement* Date (month -day-year)	☐	☐		f. ACAA´S Insurance Date (month -day-year)	☐	☐	
Holidays Date (month -day-year)	☐	☐		g. Veterans Date (month -day-year)	☐	☐	
Voluntary Pay Date (month -day-year)	☐	☐		h. A Private Plan Date (month -day-year)	☐	☐	
b. Unemployment Insurance Date (month -day-year)	☐	☐		i. Other (Specify) Date (month -day-year)	☐	☐	

*** In affirmative case, you must send copy of the letter of approval of Social Security or Pension and copy of documents of the CFSE, if it applies**

11. I became disabled (Explain how, where and when your disability occured. Include number of the complaint of the Police, if it applies).	12. My disability is related to… (In affirmative case, it includes copy of the determination or documents.) **YES** **NO** [ ] [ ] My Job SIF Claim No.(CFSE)_____ [ ] [ ] An automobile accdient
13. When I became disabled, I was: [ ] employee (a) [ ] unemployed (a)	14. During my disability I worked the period: From_____ (month-day-year) To_____ (month-day-year)
15. I recovered and I am able to work from: Date (month-day-year) 16. I returned to work in: Date (month-day-year)	17. Are you do payments to ASUME? Yes ☐ No ☐

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

CERTIFICATCION AND AUTHORIZATION

I certify that I am or I was disabled to work and that all the information provided by my in this form is certain. I know that the Law, in its Sections 3 (o) and 11 (a), imposes serious punishments---as it fines, jail or both pains, to discretion of Court-by offering deception in order to obtain disability benefits. I authorize my employer and doctor or any other natural or legal people, to provide to the Disability Insurance Program (SINOT) of the Department of Labor and Human Resources, all the information necessary for the processing of my application.

Claimant´s Signature (or mark, if unable to sign)	**Date (month-day-year)**
Witness´ name (Printed)	Witness' address:
Witness´ signature	Phone: