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| C:\Users\jsantos\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\5K7KOCLJ\Logo CFSE-Gobierno 2017 (006).png |  |
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|  |
| Servicios Regionales |
| **SOLICITUD DE AMPLIACIÓN DE PÓLIZA DE SEGURO OBRERO** |
|  |
| **SECCION I : INFORMACIÓN GENERAL** |
| Nombre del Patrono: |  |
|  |
| Número de Póliza:  |  |  |
|  |
| Seguro Social Individual o Patronal: |  |  |
|  |
| Tipo de Ampliación |  [ ]  Nómina | [ ]  Riesgo y Nómina | [ ]  Ajuste a Plazos ( Póliza Eventual) |
| (Puede seleccionar más de un tipo de ampliación) |
|  |
| Dirección Postal- Urbanización – Condominio – Barrio – Número – Calle – Pueblo - País y Zona Postal: |
|  |
|  |
| Teléfono Residencial: | **(****)**  | Teléfono Negocio: | **(****)** |  | Fax: | **(****)** |
|  |
| E-Mail: |  |  |
|  |
| Detalle todas las actividades a realizar (sea específico) | Núm. Empleados | Nómina Estimada por Actividad |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |
| Fecha de Inicio de Operaciones(día-mes-año) |  | Duración Estimada de Operaciones(en meses) |  | Fecha de Terminación Operaciones(día-mes-año) |
|  |
| Contrato con: |  |  | Monto Total del Contrato: |  |
|  |  |   |  |
| Caso ARPE: |  |  | Presupuesto ARPE: |  |
|  |
|  |
| **SECCION II : LOCALIDADES QUE SERÁN ASEGURADAS** |
| Nombre del Negocio:  |       |
|  |
| Dirección Física:  |  |
|  |  |
|  |
| Pueblo: |  | Zona Postal: |  | Estado: |  |
|  |
| Nombre del Negocio: |  |
|  |
| Dirección Física: |  |
|  |  |
|  |
| Pueblo: |  | Zona Postal: |  | Estado: |  |
|  |
| CERTIFICO que los datos ofrecidos anteriormente son correctos y exactos y en consideración a los mismos, por la presente solicito se nos emita una ampliación a nuestra póliza de seguro obrero para cubrir nuestra responsabilidad bajo las disposiciones de la Ley del Sistema de Compensaciones por Accidentes del Trabajo. |
|  |  |  |  |
| Nombre y Título del Patrono o su Representante Autorizado |  | Firma del Patrono o Representante |
|  |
| Deberá indicar un número de identificación (preferiblemente fotocopia de licencia de conducir) de la persona que entrega el documento a la Corporación. |
|  |  |  |
| Número de Identificación  |  | Clase |
| **PARA USO DE LA CFSE** |
| VIGENCIA: La ampliación de esta póliza estará en vigor desde |  | a las |  | y expira el  |  |
|  (día-mes-año) |  | (día-mes-año) |
| Sujeto a las condiciones y limitaciones consignadas en ella misma y en la Ley y Reglamentos de la Corporación del Fondo del Seguro del Estado |
| . |
|  |  |  |  |  |
|  |  |  |  |  |  |
| Fecha (día-mes-año) |  | Nombre y Firma Oficial de Investigaciones y Seguros |  | Nombre y Firma Jefe Formalización de Pólizas |
|  |  |  |  |  | **CFSE 02-126** |
|  |  |  |  |  | (CFSE-0671) |
|  |  |  |  |  | febrero/2017 |



|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |
| Regional Services |  |  |
| **INSURANCE ENDORSEMENT APPLICATION** |
|  |
| **SECCION I : GENERAL INFORMATION** |
|  |
|  Employer’s: Name |  |
|  |
|  Policy Number:  |  |  |
|  |
|  Employer’s Identification Number: |  |  |
|  |
|  Endorsement Type: A.[ ]  Payroll B.[ ]  Risk and Payroll C.[ ]  Term Adjustments (Temporary Policy)  |
|  You can choose Multiple Endorsement Type  |
|  |
|  Mailing Address – PO Box or Street, Residencial Development or Neighborhood: |
|  |  |
|  |
|  Residencial Telephone: | **(    )** | Business Telephone: | **(    )** | Fax: | **(    )** |
|  |
|  E Mail: |  |  |
|  |  |  |  |
|  Detail all Activities that you will perform(be specific) | Employees Number | Estimated Payroll by Activity |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Starting Operation Date(Month-Day-Year) |  | Estimate Operation Term (in months) |  | Estimate Ending Operation Date (Month-Day-Year) |
|  |
|  Contract: |  | Total Contract: Amount |  |
|  |  |   |  |
|  Case Number in OGPe (Permit Office): |  |  Budget by OGPe (Permit Office): |  |
|  If applicable If applicable |
|  |
| **SECTION II : LOCATIONS TO BE INSURED** |
| Business Name: |  |
|  |
| Physical Address: |  |
|  |  |
|  |
| City: |  | Zip Code: |  | State: |  |
|  |
| Business Name: |  |
|  |
| Physical Address: |  |
|  |  |
|  |
| City: |  | Zip Code: |  | State: |  |
|  |
| I certify that the data provided above are correct and accurate and therefore I am requesting an extension or endorsement to our workers compensation insurance policy to cover our responsibility under the provisions of the Workers Accident Compensation Act. |
|  |  |  |
| Employer Name and Title or Authorized Representative |  | Employer Signature or Authorized Representative |
|  |
| You must indicate a number of identification (driver’s license copy preferably) of the person who delivers the document to the SIFC. |
|  |  |  |
| Identification Number  |  | Type |
| **FOR SIFC USE ONLY** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| COVERAGE: The endorsement of this policy will be in force from  |  | at |  | and will expire on  |  |
|  (Month-Day-Year) | (Month-Day-Year) |  | (Month-Day-Year) |
| subject to the conditions and limitations contained in herself and in the law and regulations of the State Insurance Fund Corporation |
|  |
|  |  |  |  |  |
|  |  |  |  |  |
| (Month- Day-Year) |  | Insurance Officer Name and Signature |  | Underwriting Section Manager Name and Signature |
|  |  |  |  |  |  | **CFSE 02-126** |
|  |  |  |  |  |  | (CFSE-0671.1) |
|  |  |  |  |  |  | May/2017 |