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| Servicios Regionales | | | | | | | | | | | |
| **SOLICITUD DE AMPLIACIÓN DE PÓLIZA DE SEGURO OBRERO** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **SECCION I : INFORMACIÓN GENERAL** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nombre del Patrono: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Número de Póliza: | | | | |  | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Seguro Social Individual o Patronal: | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
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| Tipo de Ampliación | | | | Nómina | | | | | | | | | Riesgo y Nómina | | | | | | | | | | Ajuste a Plazos ( Póliza Eventual) | | | | | | | | | | | | | | | | | | | |
| (Puede seleccionar más de un tipo de ampliación) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Dirección Postal- Urbanización – Condominio – Barrio – Número – Calle – Pueblo - País y Zona Postal: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Teléfono Residencial: | | | | | **(****)** | | | | | | Teléfono Negocio: | | | | | | | | | **(****)** | | | | | | | | | | | | |  | | Fax: | | | **(****)** | | | | |
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| E-Mail: | |  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
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| Detalle todas las actividades a realizar (sea específico) | | | | | | | | | | | | | | | | | | | | | | Núm. Empleados | | | | | | | | | | | | | | | Nómina Estimada por Actividad | | | | | |
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| Fecha de Inicio de Operaciones  (día-mes-año) | | | | | |  | Duración Estimada de Operaciones  (en meses) | | | | | | | | | | | | | | | | | | |  | | Fecha de Terminación Operaciones  (día-mes-año) | | | | | | | | | | | | | | |
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| Contrato con: | | |  | | | | | | | | | | |  | | Monto Total del Contrato: | | | | | | | | | | | | |  | | | | | | | | | | | | | |
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| Caso ARPE: | | |  | | | | | | | | | | |  | | Presupuesto ARPE: | | | | | | | | | | | | |  | | | | | | | | | | | | | |
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| **SECCION II : LOCALIDADES QUE SERÁN ASEGURADAS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nombre del Negocio: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Dirección Física: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Pueblo: | |  | | | | | | | Zona Postal: | | | | | | | |  | | | | | | | | | | | | Estado: | | | | | | |  | | | | | | |
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| Nombre del Negocio: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Dirección Física: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Pueblo: | |  | | | | | | | Zona Postal: | | | | | | | |  | | | | | | | | | | | | Estado: | | | | | | |  | | | | | | |
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| 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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Nombre y Título del Patrono o su Representante Autorizado | | | | | | | | | | | | | | | | | | |  | | | | Firma del Patrono o Representante | | | | | | | | | | | | | | | | | | | |
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| Deberá indicar un número de identificación (preferiblemente fotocopia de licencia de conducir) de la persona que entrega el documento a la Corporación. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Fecha (día-mes-año) | | | | | | |  | Nombre y Firma Oficial de Investigaciones y Seguros | | | | | | | | | | | | | | | | | | | | | | |  | Nombre y Firma Jefe Formalización de Pólizas | | | | | | | | | | |
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| Regional Services | | | | |  | | | | | | | | | | |  |
| **INSURANCE ENDORSEMENT APPLICATION** | | | | | | | | | | | | | | | | |
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| **SECCION I : GENERAL INFORMATION** | | | | | | | | | | | | | | | | |
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| Employer’s: Name | | |  | | | | | | | | | | | | | |
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| Policy Number: | | |  | | | | | |  | | | | | | | |
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| Employer’s Identification Number: | | | | |  | | | |  | | | | | | | |
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| Endorsement Type: A. Payroll B. Risk and Payroll C. Term Adjustments (Temporary Policy) | | | | | | | | | | | | | | | | |
| You can choose Multiple Endorsement Type | | | | | | | | | | | | | | | | |
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| Mailing Address – PO Box or Street, Residencial Development or Neighborhood: | | | | | | | | | | | | | | | | |
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| Residencial Telephone: | | | | **(    )** | | | Business Telephone: | | | | **(    )** | | | Fax: | **(    )** | |
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| E Mail: | |  | | | | | |  | | | | | | | | |
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| Detail all Activities that you will perform(be specific) | | | | | | | | | | | | Employees Number | Estimated Payroll by Activity | | | |
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| Starting Operation Date  (Month-Day-Year) | | | |  | Estimate Operation Term (in months) | | | | | | |  | | Estimate Ending Operation Date  (Month-Day-Year) | | |
|  | | | | | | | | | | | | | | | | |
| Contract: | |  | | | | | | | Total Contract: Amount | | | | | |  | |
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| 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: | | |  | | | | | | | | | | | | | |
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| City: |  | | | | | | Zip Code: | | |  | | | State: | | |  |
|  | | | | | | | | | | | | | | | | |
| Business Name: | | |  | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| Physical Address: | | |  | | | | | | | | | | | | | |
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| City: |  | | | | | | Zip Code: | | |  | | | State: | | |  |
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| 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. | | | | | | | | | | | | | | | | |
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| Identification Number | | | | | | | |  | | | Type | | | | | |
| **FOR SIFC USE ONLY** | | | | | | | | | | | | | | | | |

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| 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 | | | | | | | | | | |
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| (Month- Day-Year) |  | Insurance Officer Name and Signature | | |  | Underwriting Section Manager Name and Signature | | | | |
|  |  |  | | |  |  | |  | **CFSE 02-126** | |
|  |  |  | | |  |  | |  | (CFSE-0671.1) | |
|  |  |  | | |  |  | |  | May/2017 | |