

## Republic of the Philippines SOCIAL SECURITY SYSTEM DISABILITY CLAIM APPLICATION

Please read instructions at the back before filling out this form. Print all information in black ink only.

TO BE FILLED OUT BY MEMBE	R (except f	for entries	shaded (	gray)			
A. PERSONAL DATA							
SS NUMBER NAME OF MEMBER (Surname)	(Giv	ven Name)		(Middle	Name)	TRANSACT	TION NO.
ADDRESS (No. & Street) (Barangay) (Tow	wn/ District)			(City/ P	rovince)	POS	TAL CODE
TELEPHONE/MOBILE NUMBER GENDER	TYPE OF C	CLAIM			TIN		
	□ss	CLAIM	ΠFC	CLAIM		11	11
PREFERRED MODE OF PAYMENT, IF PENSION NAME OF BANK/BRANCH		OL7 IIII		027 11117	BRSTN		1000
					1		1 1
☐ CASH CARD ☐ ATM/PASSBOOK ☐ BANK ADDRESS				Isi	NGLE SAVIN	GS ACCOU	NT NO.
DANK ADDITES					1 1 1		
B EMPLOYMENT HIGTORY From Laborate and a Miles and a character of the control of							$ \perp$ $\perp$ $\perp$
B. EMPLOYMENT HISTORY - From latest to oldest (Use separate sheet if no	ecessary)			Γ	EMPLOYME	NT PERIOD	
NAME OF EMPLOYER/ REGISTERED BUSINESS NAME A	DDRESS			FROM	(MMYYYY)	TO (MN	
The state of the desired of William				1		ı	
1)							
				, 1		, 1 .	, , ]
2)				$\perp \perp \perp$			
2)							11
3) C. DEPENDENT CHILDREN (Below 21 years old or above 21 but incapacita	ted)				1		
NAME OF DEPENDENT/S FROM YOUNGEST TO OLDEST		E OF BIR	 TH		E CHECK MARK		
(SURNAME/GIVEN NAME/MIDDLE NAME)		MDDYYYY)		YES	ITIMATE NO	INCAPAC YES	NO NO
	, 1	, 1 5					
1)	$\perp \perp \perp$		$\bot \bot$	-	-		
2)	1,1		1 1				
2)	<del></del>			<del> </del>	-		
3)		1   1	1.1				
4)							
	. 1	. I .					
5)							
MEMBER'S CI I certify to the correctness of the above information and;  that the above-mentioned children are under my care and that I have not abandoned, neglected, refused to support that none of the aforesaid children are married or employed that I will immediately notify SSS should any of the above	l custody; said child ed; and	ren, nor					es;
M/A	WED						
I waive my right on the confidentiality of my medical history a	IVER	SSS repr	esentat	ives to e	xamine mv	medical	
records.							
				- 1			
•						a a	
SIGNATURE OVER PRINTED NAME DATE							
		RIG	HT THU	ив	RIGH	IT INDEX	
If unable to sign, below are the witnesses to fingerprinting:		(To	be done	in the pres	ence of SSS	pesonnel)	
1) SIGNATURE OVER PRINTED NAME DATE	2)	CICNIATI	UDE OVE	R PRINTE	DNAME	DATI	
SIGNATURE OVER PRINTED NAME DATE		SIGNATI	UNE OVE	- PHINIC	DIVANIE	DATI	
Perfora	ate Here						
DISABILITY CLA	IM ADDI	CATION			,		
ACKNOWLED							
Note: Verification of status may be made after working days upon receipt of a			ebsite (ww				
SS NUMBER NAME OF MEMBER (Surname)	(Giv	ven Name)		(Middle	Name)	TRANSACT	ION NO.
					1====		
RECEIVED BY		DATE RE	CEIVED		RECEIVING	BRANCH	
SIGNATURE OVER PRINTED NAME DESIGNATION							

	INSTR	RUCTIONS					
<ol> <li>Accomplish one (1) copy of this form without erasure and alterations.</li> <li>Affix fingerprint in the presence of an SSS personnel.</li> <li>Open a Single Savings Account (SSA) only upon instruction of an SSS personnel. Submit to this office the original and photocopy of either the passbook or ATM card with a deposit slip stamped received by the bank.</li> </ol>							
REQUIREMENTS							
1)	Disability Claim Application	- To be accompished by member					
2)	Medical Certificate	- To be accomplished by attending physician					
Employment Data, for member applying for Employee's Compensation		- To be accomplished by employer					
4)	4) SS Card or E-6 Acknowledgement Stub with 2 valid IDs						
<ul> <li>Supporting documents</li> <li>a. Operating Room Record, if operated</li> <li>b. Clinical/Hospital Abstract, if confined</li> <li>c. Laboratory/Diagnostic Results</li> </ul>		- To be secured from hospital diagnostic center					
	<ul> <li>Xray of affected area</li> <li>ECG</li> <li>Ultrasound</li> <li>MRI/CT scan</li> <li>Blood chemistry results</li> </ul>	- To be secured from hospital/ diagnostic center					
	W	7BNING					
WARNING  ursuant to Sec. 28 of the SOCIAL SECURITY LAW as amended, anyone who resorts to misrepresentation or concealment of a material act or who is a party thereto, for the purpose of causing any payment of fraudulent claim or benefit under the said law, shall suffer the enalties of fine or imprisonment or both.							
	FOR SS	S USE ONLY					
	FOR SS	S USE ONLY PRE-EVALUATION RESULTS					
) PRE							
	SCREENING RESULTS	PRE-EVALUATION RESULTS					
ORM	SCREENING RESULTS  ESENTED: SS CARD = 66 ACK, STUB = NONE	PRE-EVALUATION RESULTS  SUPP. DOCS.:   COMPLETE  PLEASE SUBMIT (see Remarks)					
ORM N-LII	SCREENING RESULTS  ESENTED: SS CARD SE6 ACK, STUB NONE  ACCOMPLISHMENT: COMPLETE SEE REMARKS	PRE-EVALUATION RESULTS  SUPP. DOCS.:   COMPLETE   PLEASE SUBMIT (see Remarks)  ERASURES/ALTERATIONS:   NONE   SEE ENCIRCLED ITEMS  PHYSICIAN DATABASE MODULE (PDM)					
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RE-COMPUTATION OR ADJUSTMENT AND FILING OF PETITION ASSAILING SETTLED CLAIMS SHALL NOT BE ALLOWED AFTER TEN

Note:

(10) YEARS FROM THE DATE OF INITIAL SETTLEMENT OF CLAIM.