MITSUKOSHI MOTORS PHILIPPINES, INC.		
POLICY AND PROCEDURE		
POLICY TITLE :	**SOCIAL SECURITY SYSTEM BENEFITS**	Ref. No.
DEPARTMENT :	HUMAN RESOURCES DEPARTMENT	HRD-15-10-016
TO :	BRANCH MANAGER, CASHIER, ASST. CASHIER, CREDIT SUPERVISOR, ACCOUNT COUNSELOR, MARKETING ASSISTANT, BRANCH MECHANIC	JANUARY 05, 2016

OBJECTIVE:

1. To establish guidelines in availing Social Security System (SSS) benefits.
2. To ensure valid and complete documentations in processing these benefits.

POLICY:

1. Employees can enjoy SSS benefits provided they had complied with following contributions;

   SSS Loan : Thirty Six (36) Months Contributions
   SSS Sickness : 6 months. Active contribution prior to the semester of contingency
   SSS Maternity : 6 months. Active contribution prior to the semester of contingency
   SSS EC : 6 months or Less Provided it is Work Related

2. Supporting documents and information should be complete to process the next steps. It is the employee's responsibility to ensure completeness of relevant documents to expedite processing of benefits. Failure to comply with the mandatory requirements shall mean no processing of any loans or request.

PROCEDURE:

1. SSS Loan
   1.1. Employee
      1.1.1. Apply loan to SSS via online.
         1.1.1.1 Go to the SSS website (www.sss.gov.ph) and create an account.
         1.1.1.2 Change the password once account has been created.
         1.1.1.3 Click E-Services and select "Apply Salary Loan"
      1.1.2. Inform HR Associate-Benefit-In-Charge of the SSS loan application.
   1.2. HR Associate-Benefit-In-Charge
      1.2.1. Upon receipt of information from concerned employee of his/her SSS loan, certify the application via online.
         1.2.1.1. The employee will receive an email from the SSS that the employer has certified the loan application
      1.2.2. Upon receipt of SSS check for employee's loan, inform and send to the branch of the concerned employee with the Acknowledgment Receipt.
   1.3. Employee

1.3.1. Receive SSS check from HR Associate-Benefit-In-Charge and affix signature in the Acknowledge Receipt.

1.3.2. Forward duly signed Acknowledgement Receipt to HR Department-Benefit-In-Charge

1.4. HR Associate-Benefit-In-Charge

1.4.1. Receive duly signed Acknowledgement Receipt from concerned existing employee.

1.4.2. File received Acknowledgement Receipt to existing employee's 201 File.

2. SSS Sickness Benefits

2.1. Employee

2.1.1. Inform HR Associate-Benefit-In-Charge of his/her sickness or injury within five-(5) calendar days after start of his/her hospitalization for out-patient or after the discharge if confined.

2.1.2. Secure a Sickness Notification Form (CLD-9N) from the nearest SSS branch

2.1.3. Fill up the sickness Notification Form.

2.1.3.1. Part I - to be filled up by the Employee
2.1.3.2. Part II - to be filled by the Physician
2.1.3.3. Part III - to be filled by the Employer thru Benefit In-charge

2.1.4. After accomplishing the Sickness Notification Form (CLD-9N), the employee or his/her representative shall submit two (2) copies to HR Department-Benefit-In-Charge.

2.1.5. Attach the following requirements upon submission to HR Department-Benefit-In-Charge.

2.1.5.1. All Original Laboratory Examinations Results,
2.1.5.2. Photocopy of Company ID
2.1.5.3. Any photocopy of Valid ID

2.1.5.3.1. Passport
2.1.5.3.2. Driver's License
2.1.5.3.3.. Professional Regulation Commission (PRC) ID
2.1.5.3.4. Social Security System (SSS) Card
2.1.5.3.5. Postal ID
2.1.5.3.6. Voter's ID

2.2. HR Associate-Benefit-In-Charge

2.2.1. Receive Sickness Notification Form (CLD-9N) with requirements from employee or his/her representative.

2.2.2. Record the receipt of the Sickness Notification Form (CLD-9N) or knowledge of the sickness or injury in the control logbook.

2.2.3. File the duly accomplished SSS Sickness Notification Form (CLD-9N) with requirements to SSS office within 10 days from date of contingency to avoid late filing.

2.2.3.1. Notify the Medical Evaluation Section of the nearest SSS branch or Representative Office within five (5) days.

2.2.3.2. Submit the ORIGINAL SSS Sickness Notification Form (CLD-9N) and requirements to the Medical Evaluation Section of the SSS branch or Representative Office within the prescribed period.

2.2.3.2.1. SSS shall evaluate the submitted SSS Sickness Form and inform the employer of the approved number of days.
2.2.3.2.2. The SSS Sickness Notification Form (CLD-9N) will be returned to the employer's representative upon notification and upon giving the approved number of days.

2.2.4. When approved number of days had been received, inform the concerned employee and have him/her fill up the Reimbursement Form with attachment of actual premium for computation.

2.2.5. Compute for the claim and submit the Sickness Notification Form (CLD-9N), requirements and the Reimbursement Form to SSS office.

2.2.5.1. The SSS approval and advice will take at least a month.

2.2.6. When approved, the SSS will credit the account of the employer for the approved amount of medical reimbursement of the employee.

2.2.7. Check in the SSS web site if the approved amount was already credited to the company and print the Sickness Reimbursement approval of the SSS.

2.2.8. Forward Sickness Reimbursement approval of the SSS to Operations Support Department for check preparation in favor of the employee

3. Availment of Employee Compensation (EC) Claim

3.1. Employee

3.1.1. The employee, who suffered work-connected sickness or injury resulting in disability, or their families in case of work-connected death, may file claims for Employees' Compensation benefits at the SSS. These benefits are addition to what the workers or their families are entitled to under the SSS program.

3.1.2. Same procedure with Sickness Benefit except for the following additional requirements (all must be original copy).

3.1.2.1 Police report;
3.1.2.2 Company logbook or records citing the accident that had happened involving the employee in company premises;
3.1.2.3 Incident Report
3.1.2.4 Attendance logbook or records of the employee

4. Availment of Maternity Benefit

4.1. Employee

4.1.1. Immediately advise the HR Associate-Benefit-In-Charge upon the knowledge of her pregnancy.

4.1.2. Secure Maternity Notification Form (MAT-1) on the SSS via online www.sss.gov.ph https://www.sss.gov.ph/sss/uploaded_images/forms/editable/maternity%20notification_form2010_fillin.pdf or ask a copy from HR Department-Benefit-In-Charge.

4.1.3. Fill up Maternity Notification Form (MAT-1) and submit to HR Department-Benefit-In-Charge with the following requirements.

4.1.3.1. Original Ultrasound result
4.1.5.2. Photocopy of Company ID
4.1.5.3. Any photocopy of Valid ID

4.1.5.3.1. Passport
4.1.5.3.2. Driver's License
4.1.5.3.3..Professional Regulation Commission (PRC) ID

4.1.5.3.4. Social Security System (SSS) Card
4.1.5.3.5. Postal ID
4.1.5.3.6. Voter's ID

4.2. HR Associate-Benefit-In-Charge

4.2.1. Receive Maternity Notification Form (MAT-1) with requirements from pregnant employee.

4.2.2. Submit received Maternity Notification Form (MAT-1) with complete requirements to the SSS office.

4.2.2.1. While waiting for the maternity benefit, the pregnant employee can avail of the company's Cash Advance Program. The amount that can be availed depends on the employee's contributions.

4.3. Employee

4.3.1. Fill up Cash Advance Form and submit it together with the SSS premium print out to HR Department-Benefit-In-Charge for approval of the Human Resources Manager.

4.3.2. After giving birth, file Maternity Reimbursement Form (MAT-2).

4.3.3. Secure the Maternity Reimbursement Form (MAT-2) from either the nearest SSS office or coordinate with the HR Department-Benefit-In-Charge.

4.3.4. Forward duly accomplished Maternity Reimbursement Form (MAT-2) to HR Department with the following requirements:

4.3.4.4. For Normal Delivery (60 days):

4.3.4.4.1. Maternity reimbursement form
4.3.4.4.2. OB History
4.3.4.4.3. Birth Certificate - certified true copy from the Civil Registry
4.3.4.4.4. Print out of actual premiums
4.3.4.4.5. Two (2) valid ID

4.3.4.5. For Cesarean Delivery (78 days):

4.3.4.5.1. Maternity Reimbursement Form (MAT-2)
4.3.4.5.2. OB History
4.3.4.5.3. Birth Certificate of the Child – Certified True Copy
4.3.4.5.4. Discharge summary
4.3.4.5.5. Clinical abstract
4.3.4.5.6. OR/ Surgical technique – Certified true copy
4.3.4.5.7. Birth Certificate with Certified True Copy from Civil Registry
4.3.4.5.8. Print out of actual premiums

4.3.4.6. For Miscarriage

4.3.4.6.1. Maternity Reimbursement
4.3.4.6.2. OB History
4.3.4.6.3. Discharge and Clinical Report
4.3.4.6.4. Surgical Technique – certified true copy
4.3.4.6.5. Pathology Report
4.3.4.6.6. Original Copy of Ultrasound report before and after miscarriage
4.3.4.6.7. Two (2) valid ID
4.3.4.6.8. Print out of actual premiums]

4.4. HR Associate-Benefit-In-Charge

4.4.1. Receive the duly accomplished Maternity Reimbursement Form (MAT-2) with the necessary requirements from the employee.

4.4.2. File the Maternity Reimbursement Form (MAT-2) with necessary requirements to the SSS office.

4.4.2.1. If approved:

4.4.2.1.1. Wait until the SSS maternity reimbursement has been credited to the company's bank account.

4.4.2.1.2. Endorse the reimbursement details to the Treasury Department and for verification by the Payroll Section for any cash advance of the employee. Cash advance shall be deducted from the reimbursement.

4.4.2.1.3. After verification, the check will be prepared by the Treasury Department and will be released to the employee.

4.4.2.2. If disapproved, the HR Associate-Benefit-In-Charge shall coordinate with the employee for completion of additional requirements.

4.4.2.2.1. Re-file upon receipt of the additional requirements from the employee.

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SICKNESS NOTIFICATION FORM (CLD-9N)

Republic of the Philippines
SOCIAL SECURITY SYSTEM

SICKNESS NOTIFICATION
SSS Form CLD-9N (Rev. 10/74)

IMPORTANT
BEFORE ACCOMPLISHING
PLEASE READ INSTRUCTIONS

S N NO.:

PART I CONFINED MEMBER'S NOTIFICATION

Date : _____

(This Block to be accomplished by confined member. Please print all data.)

Name of Confined Member:	SS Number:	Tax Account Number:
Name of Employer:	Residence:	
Address of Employer:	Exact Date Confinement Started	Place/Address of Confinement:

This is to notify my employer that I am currently confined. The name of my employer, the place/address and the date when such confinement started are indicated above. I certify that I am hereby waiving in favor of the SSS all information which my physician has acquired while attending to me as a patient in a professional capacity which information was necessary to enable him to act in that capacity. I hereby consent to the examination of my physician as to all information acquired by him from physical/mental examination of my person and all results of X-ray, laboratory, and/or special diagnostic examination. I further waive all information held privilege by law.

Name & Signature of member's Authorized Representative (IF SICK MEMBER CANNOT WRITE: PRINT RIGHT THUMBMARK) (Please sign over your printed name)	(RIGHT THUMBMARK)	(Signature of Confined Member)

PART II MEDICAL CERTIFICATE

(This Block to be filled by the Attending Physician) Date: _____

I CERTIFY THAT I HAVE EXAMINED/ATTENDED TO the above-named employee and state the following:

1. (a) Exact Date Examined/Attended:	(b) Age:	(c) Sex:	(d) Civil Status:	(e) Occupation:

2. Address of Confinement :

3. THIS IS BEING SUBMITTED AS: (Check applicable box & state corresponding report/findings.)

☐ an INITIAL certificate ☐ an INTERMEDIATE certificate ☐ a FINAL certificate

CLINICAL SUMMARY: (Please read accompanying instructions.)

3(a) PROLONGED CONFINEMENT DUE TO:

(Give progress report of patient)

4. DIAGNOSIS:

4(a) FINAL DIAGNOSIS

IN MY MEDICAL OPINION the confinement including the convalescing or recuperation period may last for _____ days. FIT TO RESUME WORK ON _____ (Estimated Date)

NO. OF DAYS OF CONFINEMENT EXTENSION (days)

EFFECTIVE (Exact Date)

CONFINED AT

WILL BE FIT TO RESUME WORK ON (Exact Date)

☐ Confinement NOT VERIFIED by employer/company physician

☐ Confinement VERIFIED by employer/company physician

PRINTED NAME & SIGNATURE OF ATTENDING PHYSICIAN		PRINTED NAME & SIGNATURE OF EMPLOYER/COMPANY PHYSICIAN	
ADDRESS		ADDRESS	
REGISTRATION NO.	TELEPHONE NO.	REGISTRATION NO.	TELEPHONE NO.

(PART III of this form at back also to be filled up)

EMPLOYER'S/COMPANY'S ACKNOWLEDGEMENT RECEIPT (FROM SSS)	EMPLOYEE'S ACKNOWLEDGEMENT RECEIPT (FROM COMPANY)
Name of Confined Member:	Name of Confined Member:
EMPLOYER	ADDRESS
ADDRESS	EMPLOYER
CONFINEMENT PERIOD (Exact date) FROM TO	START OF CONFINEMENT (Exact Date)
RECEIVED BY	NOTIFICATION RECEIVED BY
DATE RECEIVED	DATE RECEIVED

Internet Edition (7/2000)

MATERNITY NOTIFICATION (MAT-1)

Republic of the Philippines
SOCIAL SECURITY SYSTEM

MAT-1
REV. 03-99

MATERNITY NOTIFICATION

(Please read instructions at the back. Print all information in black ink.)

SS NUMBER

TYPE OF MEMBERSHIP (CHECK APPLICABLE BOX)
☐ EMPLOYED ☐ VOLUNTARY ☐ SELF-EMPLOYED ☐ SEPARATED _____ Date of Separation

NAME *(SURNAME)* *(GIVEN NAME)* *(MIDDLE NAME)*

HOME ADDRESS *(NUMBER & STREET)* *(BARANGAY)*

(TOWN/DISTRICT) *(CITY/PROVINCE)* POSTAL CODE

THIS IS TO NOTIFY MY EMPLOYER/SSS THAT I AM EXPECTING TO GIVE BIRTH ON _____. BELOW IS MY PREGNANCY HISTORY.

	DELIVERY/IES	MISCARRIAGE/S
NUMBER		
LAST DATE		

_____ SIGNATURE

_____ DATE

FOR EMPLOYER USE

EMPLOYER ID NUMBER

EMPLOYER NAME

ADDRESS *(NUMBER & STREET)* *(BARANGAY)*

(TOWN/DISTRICT) *(CITY/PROVINCE)* POSTAL CODE

THIS IS TO CERTIFY THAT THE ABOVE-NAMED MEMBER IS PREGNANT AND IS EXPECTED TO GIVE BIRTH ON THE DATE STATED ABOVE.

_____ NAME OF EMPLOYER'S AUTHORIZED REPRESENTATIVE

_____ SIGNATURE

_____ DATE

FOR SSS USE

PROCESSED/DATE

_____ SIGNATURE OVER PRINTED NAME

RECEIVED/DATE

CUT HERE

MAT-1
REV. 03-99

MATERNITY NOTIFICATION STUB
THIS WILL BE KEPT BY SSS FOR REFERENCE PURPOSES

RECEIVED/DATE

SS NUMBER

NAME *(SURNAME)* *(GIVEN NAME)* *(MIDDLE NAME)*

Internet Edition (7/2000)

MATERNITY REIMBURSEMENT FORM (MAT-2)

MAT-2
REV. 03-99

Republic of the Philippines
SOCIAL SECURITY SYSTEM
MATERNITY REIMBURSEMENT
(Please read instructions at the back. Print all information in black ink.)

SS NUMBER

TYPE OF MEMBERSHIP (CHECK APPLICABLE BOX)
☐ EMPLOYED ☐ VOLUNTARY ☐ SELF-EMPLOYED ☐ SEPARATED _____ Date of Separation

NAME *(SURNAME)* *(GIVEN NAME)* *(MIDDLE NAME)*

HOME ADDRESS *(NUMBER & STREET)* *(BARANGAY)*

(TOWN/DISTRICT) *(CITY/PROVINCE)* POSTAL CODE

START OF MATERNITY LEAVE *M M D D Y Y Y Y*

DATE OF DELIVERY/MISCARRIAGE *M M D D Y Y Y Y*

TYPE OF DELIVERY *(CHECK APPLICABLE BOX)*
☐ NORMAL
☐ CESAREAN
☐ MISCARRIAGE

NUMBER OF PREGNANCY/IES
___ COMPLETE DELIVERY/IES
___ MISCARRIAGE/ABORTION

TOTAL MONTHLY SALARY CREDIT _____

I CERTIFY THAT THE ABOVE-STATED INFORMATION ARE CORRECT.

_____
SIGNATURE

FOR EMPLOYER USE

EMPLOYER'S ID NUMBER

EMPLOYER'S NAME

HOME ADDRESS *(NUMBER & STREET)* *(BARANGAY)*

(TOWN/DISTRICT) *(CITY/PROVINCE)* POSTAL CODE

THIS IS TO CERTIFY THAT THE MATERNITY BENEFIT OF THE ABOVE-NAMED MEMBER HAS BEEN PAID IN THE AMOUNT OF _____ _____P (_____) ON _____ AND THAT THE ABOVE INFORMATION ARE CORRECT.

_____ NAME OF EMPLOYER'S AUTHORIZED REPRESENTATIVE
_____ SIGNATURE
_____ DATE

FOR SSS USE

PROCESSED / DATE:

_____
SIGNATURE OVER PRINTED NAME

RECEIVED / DATE:

Cut Here

MAT-2
REV. 03-99

ACKNOWLEDGEMENT STUB
MATERNITY REIMBURSEMENT

EMPLOYER'S ID NUMBER

EMPLOYER'S NAME

RECEIVED / DATE:

SS NUMBER

NAME *(SURNAME)* *(GIVEN NAME)* *(MIDDLE NAME)*

DATE OF DELIVERY/MISCARRIAGE

OTHER DOCUMENTS SUBMITTED *(CHECK APPLICABLE BOX)*
☐ MAT-1 ☐ COPY OF REGISTERED BIRTH CERTIFICATE ☐ OTHERS _____

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