DISABILITY BENEFITS
INCOME BENEFITS CLAIM FOR PAYMENT

PART I - EMPLOYEE TO FILL IN ALL ITEMS

EMPLOYEE NAME (Last, First, Middle)	**CIVIL STATUS**	Married Single	Separated Widow/Widower
	GSIS POLCY OR BP NUMBER		
HOME ADDRESS	**GENDER**	Female	Male
	DATE OF BIRTH:		
DATE OF ORIGINAL APPOINTMENT	PLACE OF BIRTH:		
ACTUAL DUTIES:	**MONTHLY SALARY:** BASIC: ALLOWANCE:		

DEPENDENTS	DATE OF BIRTH	RELATIONSHIP
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

WORKING HOURS:

SPECIFIC PLACE OF WORK:

CERTIFICATION:
I CERTIFY THAT I USED ______ DAYS OF HOSPITALIZATION AND WAS PAID BY MY EMPLOYER AN AMOUNT OF _______________ CHARGEABLE AGAINST MY LEAVE CREDITS.

SIGNATURE OF EMPLOYEE/CLAIMANT
(IF UNABLE TO WRITE AFFIX THUMBMARK)

CLAIMANT'S RIGHT THUMBMARK

WITNESS TO THUMBMARK
1.
2.

Have you received or recovered any amount of damages connected with this claim from third parties. If you, state amount, name and address of such third party

If no, do you intend to recover any amount or damages from 3rd person?

If yes, please state name and address of such 3rd person

Have you chosen benefits under other laws?	If yes, what benefit and under what law?
Have you received benefits thereunder?	How much have you received?

PART II - EMPLOYER TO FILL IN ALL TIMES

EMPLOYER'S REGISTERED NAME	DATE AND PLACE OF INJURY/SICKNESS/DEATH	
ADDRESS OF EMPLOYEE	TIME:	Was the employee injured in regular occupation?

Nature or kind of Injuiy / Sickness / Disability / Death
(Describe fully how accident happened and what the employee was doing at the time of injury, sickness, disability or death)

CERTIFICATION:
I hereby certify that the contingency has been properly recorded in our log book under Entry No.________ dated _______. I further certify that Mr./Ms./Mrs _________________ has not filed any claim under any other benefits for the same injury, disability or death. Should any claim be filed, that office will be informed immediately.

SIGNATURE OF AUTHORIZED REPRESENTATIVE	OFFICIAL CAPACITY

Printed Name of Employer's Authorized Representative:

Has injured stopped working? ____________________
If so, has he returned to work? ____________________
When?____

Amount of salaries paid for the days of absence	Equivalent Number of Days

(If papers submitted are nof sufficient, additional documents may still be required)

NOTE: Anyone who falsifies essential information requested by this or a related form may, upon conviction be subject to fine and imprisonment under the law. All data required on this form are necessary for adjudication of the claim. The GSIS will adjudicate any claim where forms are not properly or completely accomplished.

HOSPITALIZATION CLAIM FOR PAYMENT

EMPLOYEE'S COMPENSATION

PART I -HOSPITAL TO FILL IN ALL ITEMS

Hospital	Address		PMC NO.	
Patient	Date Admitted	Date Discharged	Date of Death	
Diagnosis	Hospital Charges (Ward Services)		BC	Actual
Final Diagnosis	A. Room Board & Special Charges _______ days at PhP_________			
GSIS No. / Gender (Female, Male) / Age	B. Surgical C. Medicines			

Address of Employee	**CERTIFICATION** I hereby certify that the seNlc;es clelmed are duly recorded in the patient's chart and the Information given In this form, Including the attached copy of the patient statement of actual charges Is correct .
Employer	
Address of Employer	Printed Name of Hospital Authorized Representative
For GSIS Use (Signature Verified by)	Official Capacity
Remarks	Siganture of Authorized representative / Date Signed

PART II -DOCTOR TO FILL IN ALL ITEMS

DO NOT FILL

Brief Clinical History of the Case *(For clarification, use reverse side hereof)*

For services rendered always state the nature of service, surgical operation performed, if any, and date of each	CHARGES		Code No.
	EC	Actual	
A. Name of Attending Physician/Surgeon / Address			
Signature / PMA No. / TIN	Php	Php	
Services Rendered			
B. Name of Attending Physician/Surgeon / Address			
Signature / PMA No. / TIN	Php	Php	
Services Rendered			
C. Name of Attending Physician/Surgeon / Address			
Signature / PMA No. / TIN	Php	Php	
Services Rendered			

MEDICAL EVALUATION REPORT (For GSIS use only)

Nature or Degree of Sickness/Sickness

Noted ____________________

Signature ____________________

Designation ____________________

Date ____________________

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PART III - ATTENDING PHYSICIAN"S CERTIFICATION (Fill in ALL Items)

Name of Employee	Treatment Period (exact date) From: ____________________ To: ____________________
History of present illness : (Give exact date. If Possible and include signs and symptoms up to the time of this report.)	Pertinent P.E. Findings and Laboratory procedure: Past history (only those relevant to present illness)
Final Diagnosis:	
Was the injury or illness directly caused by the employee's duties?	
Degree of disability Temporary total Permanent Total Permanent Total	Was Patient working at the time of illness?
________________________________ M.D. Signature over printed name PMA No. ______________ BIR TIN ______________ Lic. No. ______________ Date Issued ______________	Medical Evaluation Report (for GSIS use only)