Government Service Insurance System
Paseguruhan ng mga Naglilingkod sa Pamahalaan

DISABILITY BENEFITS
INCOME BENEFITS CLAIM FOR PAYMENT
Form No. 02202024-DB-IBC-REV 01

(Please Read Terms and Conditions and Documentary Requirements)

INSTRUCTIONS: Ensure that the application form is properly filled out and submit duly accomplished application form to the nearest GSIS/Handling Office.

WARNING: Direct or indirect commission of fraud, collusion, falsification, misrepresentation of facts, or any other kind of anomaly in the accomplishment of this form, or in obtaining any benefit under this application shall be subject to administrative, civil and/or criminal action.

PART I – EMPLOYEE TO FILL IN ALL ITEMS

EMPLOYEE NAME (Last, First, Middle)

HOME ADDRESS

DATE OF ORIGINAL APPOINTMENT asd

ACTUAL DUTIES:

Dependents	Date of Birth	Relationship
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

CIVIL STATUS ☐ Married ☐ Single ☐ Separated ☐ Widow/Widower

GSIS POLICY OR BP NUMBER

GENDER

DATE OF BIRTH

PLACE OF BIRTH

MONTHLY SALARY:
Basic:
Allowance:

CERTIFICATION:
I certify that I used _____ days of hospitalization and was paid by my employer an amount of _____ chargeable against my leave credits.

DATA PRIVACY CONSENT

I hereby confirm my understanding of the Privacy Policy of the GSIS pursuant to the requirements of R.A. 10173, otherwise known as the DPA, its Implementing Rules and Regulations and other issuances of the National Privacy Commission and consent to the manner of and safety measures to be observed in the collection, use, access, disclosure, processing and disposal of my personal and sensitive personal data by the GSIS.

WORKING HOURS:

SPECIFIC PLACE OF WORK:

_____
SIGNATURE OF EMPLOYEE/CLAIMANT
(If unable to write affix thumbmark)

WITNESSES TO THUMBMARK:
1.
2.

Claimant's Right thumbmark

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

If no, do you intend to recover any amount of 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

ADDRESS OF EMPLOYEE

DATE AND PLACE OF INJURY / SICKNESS / DEATH

TIME: | Was the employee injured in regular occupation?

Nature or kind of Injury / 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 not sufficient, additional documents may still be required)

HOSPITALIZATION CLAIM FOR PAYMENT

EMPLOYEE'S COMPENSATION

PART I - HOSPITAL TO FILL IN ALL ITEMS

Hospital	Address	PMC No.
asfasf	asfasf	asfasf

Patient/Employee	Date Admitted	Date Discharged	Date of Death
asfasf	asfasf	asfasf	asfasf

Diagnosis	Hospital Charges (Ward Services)	BC	Actual
	A. Room Board & Special Charges _____ days at Php_____		
Final Diagnosis	B. Surgical		
	C. Medicines		

GSIS No.	Gender	Age

Address of Employee

Employer

Address of Employer

For GSIS Use (Signature Verified by)

Remarks

CERTIFICATION

I hereby certify that the services claimed 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.

Printed Name of Hospital Authorized Representative

Official Capacity

Signature of Authorized Representative	Date Signed

PART II - DOCTOR TO FILL IN ALL ITEMS

Do not Fill

Code No.

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

asdasdaf

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

MEDICAL EVALUATION REPORT (For GSIS use only)

Nature or Degree of Sickness/Sickness

Noted _____

Signature _____

Designation _____

Date _____

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 procedures: 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 partial	Was patient working at the time of the illness?
_____ M.D. Signature over printed name PMA No. _____ BIR TIN _____ Lic. No _____ Date Issued _____	Medical Evaluation Report (for GSIS use only)