Government Service Insurance System
Paseguruhan ng mga Naglilingkod sa Pamahalaan

Part I – INSURED STATEMENT
TOTAL AND PERMANENT DISABILITY CLAIM
Form No. 02202024-ATPD-REV 01

Notice is hereby given to this GOVERNMENT SERVICE INSURANCE SYSTEM, Pasay City that ……..upon whose life there was issued by said System Policy No. ……..is now, as a result of the accident/illness described below, totally incapacitated from engaging in any gainful occupation, and he therefore, makes claim for disability benefits under the provisions of said policy.

In support of such claim the undersigned states the following:

1. Full Name: ……
2. Address ……
   City *Province*
3. Birthdate: ……
4. Office where employed when disability occurred:
   ……
5. Date of injury or beginning of present illness: Give detailed description of same:
   ……
   ……
6. Name of Hospital, sanitarium or dispensary clinic where treated: …… Inclusive dates of treatment: ……
   ……
7. Name and address of all physicians consulted regarding illness:
   NAME ADDRESS
   …… ……
   …… ……
8. Data when continuous inability to engage in any gainful occupation commended:
   ……
9. Records of other life insurance, Accident and Fraternal policies containing disability benefits:

Name of Company	Policy No.	Amount of Disability

WAIVER

I expressively waive, on behalf of myself and of any person who shall have or claim any interest in the above numbered policy, or policies, all provisions of law forbidding any physician or any other person who has heretofore attended or examined me, or who may hereafter attend or examine me, from disclosing any acknowledge or information, or from expressing any opinion, which that thereby acquired, or acquire; and I agree that said System shall have full right to acquire and obtain, from whomever it may, any and all the information it may desire for and before action upon this claim, and agree that the furnishing of this form, and of any forms supplemental thereto, by said System shall not constitute nor be considered a waiver of any of its rights or defenses.

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.

Signed at …… this day of …… 20 …….
(Please print name before signature)

Witness:

Right Thumbmark

…… ……
(Address of witness) Insured's Signature

PROVINCE OF……}
TOWN OF……} s.s.

On this……day of ……20…..personally appeared before me the above name…….who is known to me and who subscribed the foregoing statement before me and made oath that the foregoing answers are each and all true to the best of his knowledge and belief.

Doc No …… Page No. …… ……
Book No. Series of 20 Notary Public

Part II – CERTIFICATE OF ATTENDING PHYSICIAN
TOTAL AND PERMANENT DISABILITY CLAIM

1. Full Name: _____
2. Address _____
City *Province*

3. (a) Give a brief clinical history of the injury/ illness:

(b) Finding on physical examination including laboratory and/or X-ray examination when necessary:

(c) Diagnosis:

(d) Program:

4. Give history of any physical Impairment which to lengthen period of disability:

5. Give dates of first and last treatment: _____

First treatment (Date……) Last treatment (Date……)

6. Since what date has the patient been continuously unable to engage in any painful occupation?

7. As date of this examination, do you believe that the patient is still incapacitated from engaging in any gainful occupation? If no, how long in your opinion will the patient be still unable to engage in any gainful occupation?

8. Is the patient now mentally competent? _____

REMARKS: _____

_____ Signature of insured

Right Thumbmark

I HEREBY CERTIFY that I have examined and treated the above-named patient whose signature and thumbmark appear above, and that foregoing statement of disability is based on my personal knowledge of the case.

I hereby confirm my understanding of the Data Privacy Policy of the GSIS pursuant to the requirements of Republic Act No. 10173, otherwise known as the "Data Privacy Act of 2012", its Implementing Rules and Regulations and other issuances of the National Privacy Commission.

I consent to the manner of collection, use, access, disclosure and processing of my personal and sensitive personal information by the GSIS contained in this form and in documents submitted to support my claim. I further consent to the sharing of my personal information with other agencies whenever material and relevant to my transaction with GSIS. I am assured that security systems are employed to protect my information.

Signed this …… day of …… 20 ……
at……
(Province)

……,MD
Signature of Physician

……
Designation

……
Address

Part III – ATTENDING PHYSICIAN'S CERTIFICATION (Fill in ALL Items)

<table>
<tr><td>Name of Employee</td><td>Treatment Period (exact date)

From: _____ To: _____</td></tr>
<tr><td>History of present illness: (Give exact date, if possible and include signs and symptoms up to the time of this report)</td><td></td></tr>
<tr><td colspan="2">Final Diagnosis:</td></tr>
<tr><td colspan="2">Was the injury or illness directly caused by the employee's duties?</td></tr>
<tr><td>Degree of disability

☐ Temporary total
☐ Permanent total
☐ Permanent partial</td><td>Was the patient working at the time of the illness?</td></tr>
<tr><td>

_____ M.D.
Signature over printed name

PMA No. _____ BIR TIN: _____
Lic. No._____ Date Issued: _____</td><td>Medical Evaluation Report (for GSIS use only)</td></tr>
</table>