Republic of the Philippines
SOCIAL SECURITY SYSTEM
DISABILITY CLAIM APPLICATION

(03-2009)

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

TO BE FILLED OUT BY MEMBER (except for entries shaded gray)

A. PERSONAL DATA

SS NUMBER	NAME OF MEMBER (Surname)	(Given Name)	(Middle Name)	TRANSACTION NO.

ADDRESS (No. & Street)	(Barangay)	(Town/ District)	(City/ Province)	POSTAL CODE

TELEPHONE/MOBILE NUMBER	GENDER	TYPE OF CLAIM	TIN

GENDER: ☐ MALE ☐ FEMALE

TYPE OF CLAIM: ☐ SS CLAIM ☐ EC CLAIM

PREFERRED MODE OF PAYMENT, IF PENSION	NAME OF BANK/BRANCH	BRSTN

☐ CASH CARD   ☐ ATM/PASSBOOK

BANK ADDRESS	SINGLE SAVINGS ACCOUNT NO.

B. EMPLOYMENT HISTORY - From latest to oldest (Use separate sheet if necessary)

NAME OF EMPLOYER/ REGISTERED BUSINESS NAME	ADDRESS	EMPLOYMENT PERIOD FROM (MMYYYY)	TO (MMYYYY)
1)			
2)			
3)			

C. DEPENDENT CHILDREN (Below 21 years old or above 21 but incapacitated)

NAME OF DEPENDENT/S FROM YOUNGEST TO OLDEST (SURNAME/GIVEN NAME/MIDDLE NAME)	DATE OF BIRTH (MMDDYYYY)	LEGITIMATE YES	NO	INCAPACITATED YES	NO
1)					
2)					
3)					
4)					
5)					

PLACE CHECK MARK ON APPLICABLE BOX

MEMBER'S CERTIFICATION

I certify to the correctness of the above information and;
- that the above-mentioned children are under my care and custody;
- that I have not abandoned, neglected, refused to support said children, nor caused them to commit lawful offenses;
- that none of the aforesaid children are married or employed; and
- that I will immediately notify SSS should any of the above listed children die, marry or become employed.

WAIVER

I waive my right on the confidentiality of my medical history and allow SSS representatives to examine my medical records.

_____   _____
SIGNATURE OVER PRINTED NAME   DATE

RIGHT THUMB	RIGHT INDEX

(To be done in the presence of SSS personnel)

If unable to sign, below are the witnesses to fingerprinting:

1) _____ _____   2) _____ _____
   SIGNATURE OVER PRINTED NAME   DATE   SIGNATURE OVER PRINTED NAME   DATE

- **Perforate Here** -

DISABILITY CLAIM APPLICATION
ACKNOWLEDGEMENT STUB

Note: Verification of status may be made after _____ working days upon receipt of application thru the SSS Website (www.sss.gov.ph) or contact the nearest SSS office.

SS NUMBER	NAME OF MEMBER (Surname)	(Given Name)	(Middle Name)	TRANSACTION NO.

RECEIVED BY	DATE RECEIVED	RECEIVING BRANCH

_____   _____
SIGNATURE OVER PRINTED NAME   DESIGNATION

INSTRUCTIONS

1) Accomplish one (1) copy of this form without erasure and alterations.
2) Affix fingerprint in the presence of an SSS personnel.
3) 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.

REQUIREMENTS

1) Disability Claim Application — To be accomplished by member

2) Medical Certificate — To be accomplished by attending physician

3) Employment Data, for member applying for Employee's Compensation — To be accomplished by employer

4) SS Card or E-6 Acknowledgement Stub with 2 valid IDs

5) Supporting documents
   a. Operating Room Record, if operated — To be secured from hospital
   b. Clinical/Hospital Abstract, if confined
   c. Laboratory/Diagnostic Results — To be secured from hospital/ diagnostic center
      • Xray of affected area
      • ECG
      • Ultrasound
      • MRI/CT scan
      • Blood chemistry results

WARNING

Pursuant to Sec. 28 of the SOCIAL SECURITY LAW as amended, anyone who resorts to misrepresentation or concealment of a material fact 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 penalties of fine or imprisonment or both.

FOR SSS USE ONLY

SCREENING RESULTS

ID PRESENTED: ☐ SS CARD ☐ E6 ACK. STUB ☐ NONE

FORM ACCOMPLISHMENT: ☐ COMPLETE ☐ INCOMPLETE

ON-LINE INQUIRY: ☐ WITH FINDINGS ☐ NO FINDINGS

REMARKS:
_____
_____
_____
_____

SCREENED BY

_____ _____
SIGNATURE OVER PRINTED NAME   DATE

PRE-EVALUATION RESULTS

SUPP. DOCS.: ☐ COMPLETE ☐ PLEASE SUBMIT (see Remarks)

ERASURES/ALTERATIONS: ☐ NONE ☐ SEE ENCIRCLED ITEMS

PHYSICIAN DATABASE MODULE (PDM)
☐ NO DISCREPANCY ☐ BELONGS TO ANOTHER ☐ NOT IN PDM

REMARKS:
_____
_____
_____
_____

PRE-EVALUATED BY

_____ _____
SIGNATURE OVER PRINTED NAME   DATE

Note:
RE-COMPUTATION OR ADJUSTMENT AND FILING OF PETITION ASSAILING SETTLED CLAIMS SHALL NOT BE ALLOWED AFTER TEN (10) YEARS FROM THE DATE OF INITIAL SETTLEMENT OF CLAIM.