



DISABILITY BENEFITS
INCOME BENEFITS CLAIM FOR PAYMENT

PART I - EMPLOYEE TO FILL IN ALL ITEMS

EMPLOYEE NAME (Last, First, Middle) HERRERA, PHILIP SALVADOR , ASAMA			CIVIL STATUS ☒ Married ☐ Single ☐ Separated ☐ Widow/Widower	
HOME ADDRESS BLISS, BRGY. SENGAL, LAMITAN CITY, BASILAN			GSIS POLCY OR BP NUMBER	
DATE OF ORIGINAL APPOINTMENT			GENDER ☐ Female ☒ Male	
ACTUAL DUTIES:			DATE OF BIRTH: AUGUST 03, 1980	
			PLACE OF BIRTH: BLISS, BRGY. SENGAL, LAMITAN CITY	
			MONTHLY SALARY:	
			BASIC:	
			ALLOWANCE:	
DEPENDENTS		DATE OF BIRTH	RELATIONSHIP	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) WITNESS TO THUMBMARK 1. 2.
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
WORKING HOURS:			CLAIMANT'S RIGHT THUMBMARK	
SPECIFIC PLACE OF WORK:				

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 not 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) A. Room Board & Special Charges _____ days at Php _____ B. Surgical C. Medicines		BC	Actual
Final Diagnosis						
GSIS No.	Gender ☐ Female ☐ Male	Age				
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		Php	Php		
PMA No.	TIN				
Services Rendered					
B. Name of Attending Physician/Surgeon		Address			
Signature		Php	Php		
PMA No.	TIN				
Services Rendered					
C. Name of Attending Physician/Surgeon		Address			
Signature		Php	Php		
PMA No.	TIN				
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)

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