Government Service Insurance System
DISABILITY BENEFITS DEPARTMENT

INCOME BENEFITS CLAIM FOR PAYMENT

PART I - EMPLOYEE TO FILL IN ALL ITEMS

EMPLOYEE NAME *(Last, First, Middle)*

Civil Status: [ ] S [ ] M [ ] W GSIS Pol. No.

Home Address:

Date of Birth:

Sex: [ ] Male [ ]

Date of Original Appointment

Place of Birth

Actual Duties:

Monthly Salary:

Basic Allowance

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

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

Signature of Employee/Claimant *(If unable to write affix thumbmark)*

Claimant's Right Thumbmark

Witnesses to Thumbmark
1
2

Working Hours:

Specific Place of Work:

Have you received or recovered any amount or damages connected with this claim from third party/ies. 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 ITEMS

Employer's Registered Name:

Date & Place of Injury / Sickness / Death

Address of Employee:

Time: Was 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:

logbook under entry No. ______________ dated ______________ I further certify Mr. / Miss / Mrs. ______________

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 No. of days

(If papers submitted are not sufficient, additional documents may still be required)

NOTE: Any one who falsifies essential information requested by this or a rebited form any 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 not adjudicate any claim where forms are not properly or completely accomplished.

MEMBER'S SERVICE RECORDS

NAME: ______________________________ SEX ____________ CIVIL STATUS ____________
(Print or Type) (Surname) (Given) (Mid. Name)

ADDRESS ______________________________ BIRTH ______________________________
(Station or Place of Assignment) (Date) (Place)

SERVICE (Inclusive Dates)		RECORDS OF APPOINTMENT				Office of Entity or Division	Leave of Absence w/o Pay	REMARKS
From	To	Designation	Basic Salary	Allow.	Status (Perm/Temp)			

CERTIFIED CORRECT:

____
Signature of Authorized Representative
(Employer)

____
Date of Registration of Employee

____
Number of Monthly Premiums Paid

____
Life Retirement Medicare Employee Compensation

CERTIFIED CORRECT:

____
Chief, Billing Division