



PASEGURUHAN NG MGA NAGLILINGKOD SA PAMAHALAAN
(GOVERNMENT SERVICE INSURANCE SYSTEM)

COPY FOR:

Life Ins. Cl. Div.
Retirement Div.

Part I-INSURED'S STATEMENT

TOTAL AND PERMANENT DISABILITY CLAIM

Notice is hereby given to the GOVERNMENT SERVICE INSURANCE SYSTEM, Manila that M 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 claims 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. Birth: Date: Place:
4. Office where employed when disability occurred:
5. Date of injury or beginning of present illness: Give a detailed description of same:
6. Name of hospital, sanitarium or dispensary clinic where treated: Inclusive dates of treatment:
7. Names and addresses of all physicians consulted regarding illness:

NAME	ADDRESS
.....
8. Date when continuous inability to engage in any gainful occupation commenced:
9. Record of other life insurance, Accident and Fraternal policies containing disability benefits:

Name of Company	Policy No.	Amount of Disability
.....

W A I V E R

I expressly 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 they thereby acquired, or acquire; and I agree that said System shall have full right to acquire and obtain, from whomsoever it may, any and all the information it may desire for and before acting 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.

Signed at this day of, 199..
(Please print name before signature)



Witness:

(Address of Witness)

Insured's Signature

PROVINCE S.S.
TOWN OF

On this day of, 199... personally appeared before me the above-named 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 199..... Notary Public



**PASEGURUHAN NG MGA NAGLILINGKOD SA PAMAHALAAN
(GOVERNMENT SERVICE INSURANCE SYSTEM)
Financial Center, Roxas Blvd., Pasay City 1308**

Part 2 – Certificate of Attending Physician

TOTAL AND PERMANENT DISABILITY CLAIM

COPY FOR:

	Life Ins. Cl. Div.

1. FULL NAME: _____ AGE: _____

2. Address: _____ City: _____ Province: _____

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

.....

.....

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

.....

.....

(c) Diagnosis:

(d) Programs:

.....

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 so, how long in your opinion will the patient be still unable to engage in any gainful occupation?.....

.....

8. Is the patient now mentally competent?

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REMARKS:

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Signature of Insured

Right Thumbmark

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

Signed this day of 20 at

(Province)

....., M.D.
Signature of Physician

.....
Designation