GSIS Government Service Insurance System

DISABILITY BENEFITS
INCOME BENEFITS CLAIM FOR PAYMENT
PART I – EMPLOYEE TO FILL IN ALL ITEMS

EMPLOYEE NAME (LAST, FIRST, MIDDLE)

CIVIL STATUS ☐ Married ☐ Separated ☐ Single ☐ Widow/Widower

HOME ADDRESS

GSIS POLICY OR BP NUMBER

GENDER ☐ Female ☐ Male

DATE OF ORIGINAL APPOINTMENT

DATE OF BIRTH

PLACE OF BIRTH

ACTUAL DUTIES:

MONTHLY SALARY:

BASIC:

ALLOWANCE:

DEPENDENTS	DATE OF BIRTH	RELATIONSHIP
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

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) | CLAIMANT'S RIGHT THUMBMARK

WITNESS TO THUMBMARK

1.

2.

WORKING HOURS:

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 of 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 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:

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.

MEMBER'S SERVICE RECORDS

NAME (Print or type) (Surname) (Given) (Middle Name)

ADDRESS (Station or Place of Assignment) GENDER ☐ Female ☐ Male

DATE OF BIRTH PLACE OF BIRTH CIVIL STATUS ☐ Single ☐ Married ☐ Separated ☐ Widow/Widower

SERVICE (Inclusive Date)		RECORDS OF APPOINTMENT				Office or Entity or Division	Leave of Absences without pay	REMARKS
From	To	Designation	Basic Salary	Allowance	Status (Perm/Temp)			

CERTIFIED CORRECT.

Signature of Authorized Representative (Employer)

Date of Registration of Employee

Number of Monthly Premium Paid

Life Retirement Medicare Employees Compensation

CERTIFIED CORRECT:

Chief, Billing Division

HOSPITALIZATION CLAIM FOR PAYMENT
EMPLOYEE'S COMPENSATION

PART I - HOSPITAL TO FILL IN ALL ITEMS

Hospital	Address			PMC No.
Patient/Employee	Date Admitted		Date Discharged	Date of Death
Diagnosis	Hospital Charges(Ward Services)		BC	Actual
	A. Room Board & Special Charges _____ days at Php_____			
Final Diagnosis	B. Surgical			
GSIS No. / Gender ☐ Female ☐ Male / Age-	C. Medicines			
Address of Employee	CERTIFICATION			
Employer	I hereby certify that the services claimed 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			
Address of Employer	Printed Name of Hospital Authorized Representative			
For GSIS Use (Signature Verified by)	Official Capacity			
Remarks	Signature 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*)

Code No.

For services rendered always state the nature of service, surgical operation performed, if any, and date of each		CHARGES EC	CHARGES Actual
A. Name of Attending Physician/Surgeon	Address		
Signature / PMA No. TIN	Date Signed	Php	Php
Services Rendered			
B. Name of Attending Physician/Surgeon	Address		
Signature / PMA No. TIN	Date Signed	Php	Php
Services Rendered			
C. Name of Attending Physician/Surgeon	Address		
Signature / PMA No. TIN	Date Signed	Php	Php
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)

Name of Employee	Treatment Period (exact date) From: _____ To: _____
History of present illness: (Give exact date, if possible and include signs and symptoms up to the time of this report)	Pertinent P.E. Findings and Laboratory procedures: Past history (only those relevant to present illness)
Final Diagnosis	
Was the injury or illness directly caused by the employee's duties?	
Degree of disability ☐ Temporary total ☐ Permanent total ☐ Permanent partial	Was patient working at the time of the illness?
_____ M.D. Signature over printed name PMA No. _____ BIR TIN _____ Lic. No _____ Date Issued _____	Medical Evaluation Report (for GSIS use only)