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

GSIS POLICY OR BP NUMBER

HOME ADDRESS

GENDER ☐ Female ☐ Male

DATE OF BIRTH

DATE OF ORIGINAL APPOINTMENT

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 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 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.

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** 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
Employer	
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 / Date Signed / PMA No. TIN	Php	Php
Services Rendered		
B. Name of Attending Physician/Surgeon / Address		
Signature / Date Signed / PMA No. TIN	Php	Php
Services Rendered		
C. Name of Attending Physician/Surgeon / Address		
Signature / Date Signed / PMA No. TIN	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)