



Republic of the Philippines  
**SOCIAL SECURITY SYSTEM**  
**SICKNESS BENEFIT APPLICATION**

SIC - 01250 (12-2015) **(FOR SELF-EMPLOYED/VOLUNTARY MEMBER & MEMBER SEPARATED FROM EMPLOYMENT)**

**THIS FORM MAY BE REPRODUCED AND IS NOT FOR SALE. THIS CAN ALSO BE DOWNLOADED THRU THE SSS WEBSITE AT www.sss.gov.ph**  
PLEASE READ THE INSTRUCTIONS AT THE BACK BEFORE FILLING OUT THIS FORM. PRINT ALL INFORMATION IN CAPITAL LETTERS AND USE BLACK INK ONLY.

**PART I - TO BE FILLED OUT BY MEMBER**

**A. PERSONAL DATA**

SS NUMBER	COMMON REFERENCE NUMBER (CRN, IF ANY)	DATE OF BIRTH (MMDDYYYY)	TAX IDENTIFICATION NUMBER (IF ANY)
NAME (LAST NAME)	(FIRST NAME)	(MIDDLE NAME)	(SUFFIX)
LOCAL ADDRESS (RM./FLR./UNIT NO. & BLDG. NAME)		(HOUSE/LOT & BLK. NO.)	(STREET NAME)
(SUBDIVISION)	(BARANGAY/DISTRICT/LOCALITY)	(CITY/MUNICIPALITY)	(PROVINCE)
TELEPHONE NUMBER (AREA CODE + TEL. NO.)		MOBILE/CELLPHONE NUMBER	E-MAIL ADDRESS
FOREIGN ADDRESS (IF APPLICABLE)		COUNTRY	ZIP CODE
SICKNESS BENEFIT TYPE <input type="checkbox"/> SS <input type="checkbox"/> EC	PLACE OF CONFINEMENT <input type="checkbox"/> HOME <input type="checkbox"/> HOSPITAL	NAME OF LAST EMPLOYER: _____	
DATE OF SEPARATION FROM LAST EMPLOYER: _____			

**B. MEMBER'S ENROLLMENT IN THE PAYMENT THRU THE BANK (If not yet enrolled)**

BANK NAME AND BRANCH	BANK BRANCH ADDRESS			ZIP CODE
BANK ACCOUNT NAME				
BANK ACCOUNT NUMBER	<input type="checkbox"/> SAVINGS/CURRENT <input type="checkbox"/> UMID ATM ACCOUNT <input type="checkbox"/> CASH CARD: VALID UNTIL _____			

**C. CERTIFICATION**

I certify that the information provided in this form are true and correct.

PRINTED NAME	SIGNATURE	DATE
If member cannot sign, affix fingerprints. Please read Instruction No. 5 of the form.		
<b>Below are the witnesses to fingerprinting:</b>		
1) _____ PRINTED NAME	_____ SIGNATURE	_____ DATE
ADDRESS & CONTACT NUMBER _____		
2) _____ PRINTED NAME	_____ SIGNATURE	_____ DATE
ADDRESS & CONTACT NUMBER _____		
	RIGHT THUMB	RIGHT INDEX

**PART II-A. MEDICAL CERTIFICATE (TO BE FILLED OUT BY THE ATTENDING PHYSICIAN)**

BRIEF MEDICAL HISTORY AND PERTINENT FINDINGS			
<b>ATTENDING PHYSICIAN'S CERTIFICATION</b>			
I certify that I have seen and examined above-named patient on _____ and in my opinion, confinement including recuperation period may last _____ days. (no. of days)			
DIAGNOSIS _____			
PLACE OF CONFINEMENT <input type="checkbox"/> HOME <input type="checkbox"/> HOSPITAL	START OF CONFINEMENT (MMDDYYYY)	NAME OF HOSPITAL (If confined in a hospital)	
PRINTED NAME AND SIGNATURE			LICENSE NO.
ADDRESS OF PHYSICIAN'S CLINIC/HOSPITAL (NO & STREET)	(BARANGAY)	(TOWN/DISTRICT)	(CITY/PROVINCE)
			ZIP CODE

**PART II-B. TO BE FILLED OUT BY SSS PERSONNEL**

RECEIVED BY (FOR MEMBER SERVICES SECTION)	RECEIVED BY (FOR MEDICAL EVALUATION SECTION)
SIGNATURE OVER PRINTED NAME    DATE    TIME	SIGNATURE OVER PRINTED NAME    DATE    TIME

-----Perforate Here-----



**SOCIAL SECURITY SYSTEM**  
**SICKNESS BENEFIT APPLICATION**  
**ACKNOWLEDGEMENT STUB**

SS NUMBER/CRN (IF ANY)	NAME OF MEMBER (LAST NAME)	(FIRST NAME)	(MIDDLE NAME)	(SUFFIX)
START OF SICKNESS (MMDDYYYY)	RECEIVED BY		SIGNATURE OVER PRINTED NAME OF RECEIVING PERSONNEL	
	DATE & TIME		SSS BRANCH	

## INSTRUCTIONS

1. Fill out this form in one (1) copy.
2. Always indicate "N/A" or "Not Applicable", if the required data is not applicable.
3. Write SS number and name of member in all supporting documents for submission.
4. Present valid identification cards/documents. Refer to attached "List of Filer's Valid Identification (ID) Cards/Documents".
5. If member cannot sign, witnesses to fingerprinting shall be as follows:

### Filed by member

- SSS receiving personnel who shall affix his/her signature on the portion provided in Part I-C and indicate employee ID No.

### Filed by member's representative

- Two (2) witnesses. One (1) is the member's authorized representative and the other one (1) could be any person. Both should affix their signatures and indicate their addresses and contact numbers on the portions provided in Part I-C.

6. Accomplish Part I-B of this form, if not yet enrolled in the Payment thru the Bank Program.
7. Secure Letter of Introduction (LOI) form from SSS, if without existing single savings or current account, which shall be presented to the SSS-accredited bank chosen for purposes of opening single savings account/cash card account.
8. Submit this form to the nearest SSS branch office together with the following documentary requirements:

- a. Bank documents (photocopy/scanned copy of any of the following, to ascertain correctness of bank account information.

- ✓ ATM Card (with account number)
- ✓ Bank Account Passbook
- ✓ Bank Statement/Certificate
- ✓ Deposit Slip/Savings account number card

Sickness benefit payments shall be remitted by the SSS to member's designated bank.

- b. SSS Medical Certificate Form filled out by attending physician
- c. Supporting Medical Document, if any.

### For prolonged confinement/sickness

- ✓ Laboratory, X-ray, ECG and other diagnostic results;
- ✓ Operating room/clinical record that will support diagnosis

### For vehicular accident with 3rd party involvement (EC claim)

- ✓ Police Report

### d. Additional Required Documents

Present the original/certified true copy and submit the photocopy of the following, whichever is applicable:

#### d.1 For Self-Employed/Voluntary Member (previously employed)

##### If confinement period applied for is within the period of employment or prior to date of separation

- Certificate of separation from employment with effective date of separation and no advance payment was granted (signed by the employer's authorized signatory reflected in the Specimen Signature Card [SS Form L-501])

#### d.2 For Member Separated from Employment

##### If confinement period applied for is within the period of employment or prior to date of separation

- Certificate of separation from employment with effective date of separation and no advance payment was granted (signed by the employer's authorized signatory reflected in SS Form L-501)

##### If confinement period applied for is after the date of separation

- Certificate of separation from employment with effective date of separation (signed by the employer's authorized signatory reflected in SS Form L-501)

Certificate of separation is not required for self-employed/voluntary member (previously employed) or member separated from employment under any of the following conditions in which supporting document/s shall be required to be submitted as enumerated below:

##### If company is on strike

- Notice of strike duly acknowledged by the DOLE; and
- Duly notarized Affidavit of Undertaking issued by the member that no advanced payment was granted

##### If company has been dissolved or has ceased operation

- Duly notarized Affidavit of Undertaking issued by the member that no advance payment was granted and with indicated effective date of separation

##### If there is a case pending before a court regarding separation of member

- Certification from DOLE; and
- Duly notarized Affidavit of Undertaking issued by the member that no advance payment was granted and with indicated effective date of separation

##### If separated from employment due to AWOL or with strained relations with the employer

- Duly notarized Affidavit of Undertaking issued by the member that no advance payment was granted and with indicated reason and effective date of separation

## WARNING

ANY PERSON WHO MAKES ANY FALSE STATEMENT IN THIS APPLICATION OR SUBMITS ANY FALSIFIED DOCUMENTS IN CONNECTION WITH THE APPLICATION WITH THE SSS SHALL BE LIABLE CRIMINALLY UNDER SECTION 28 OF RA 8282 OR UNDER PERTINENT PROVISION OF REVISED PENAL CODE.

<b>SS NUMBER</b>	<b>NAME OF MEMBER</b>	(LAST NAME)	(FIRST NAME)	(MIDDLE NAME)	(SUFFIX)
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**PART III - TO BE FILLED OUT BY SSS PERSONNEL**

**A. SCREENING RESULTS**

<p><b>MEMBER SERVICES SECTION</b> Screening was done and results are as follows:</p> <p><input type="checkbox"/> In order  <input type="checkbox"/> No signature of Member  <input type="checkbox"/> Medical Certificate not accomplished</p> <p>REMARKS _____          _____          _____</p>	<p><b>MEDICAL EVALUATION SECTION</b> Screening was done and results are as follows:</p> <p><input type="checkbox"/> In order  <input type="checkbox"/> With findings, please see remarks</p> <p>REMARKS _____          _____          _____</p>
<p>SCREENED BY _____</p> <p>_____ SIGNATURE OVER PRINTED NAME      DATE      TIME</p>	<p>SCREENED BY _____</p> <p>_____ SIGNATURE OVER PRINTED NAME      DATE      TIME</p>

**B. PAYMENT THRU THE BANK PROGRAM**

<p align="center"><b>REASON FOR EXEMPTION FROM THE PROGRAM</b></p> <p><input type="checkbox"/> Member's amount of benefit is one thousand pesos (P1,000) and below  <input type="checkbox"/> Member's address is beyond 30 kms to the nearest SSS-accredited bank  <input type="checkbox"/> Member's address is in high risk area  <input type="checkbox"/> Member is physically incapable of transacting business with the bank  <input type="checkbox"/> Others</p>	<p>REMARKS _____          _____          _____</p>
<p>SCREENED AND ENCODED BY _____</p> <p>_____ SIGNATURE OVER PRINTED NAME      DATE      TIME</p>	<p>REVIEWED BY _____</p> <p>_____ BRANCH HEAD      DATE SIGNATURE OVER PRINTED NAME</p>

**C. MEDICAL EVALUATION**

**C.1 Physical Examination and Interview**

<p>PERTINENT PE FINDINGS (Member to affix signature after PEI)</p>	<p>Onset of Illness _____          Last Working Day _____          Back to Work _____</p>
<p>_____ Member's Signature</p>	

**C.2 Recommendation**

<p align="center"><b>SS</b></p> <p>APPROVED # of days  <input type="checkbox"/> Initial      <input type="checkbox"/> Extension (indicate previous approval)</p> <p>_____ (In numeric)      _____ (In words)</p> <p>_____ (Inclusive Period)</p> <p><input type="checkbox"/> Previous approval _____  <input type="checkbox"/> Hospital (Confined) _____          _____ (Date of Discharge)</p> <p><input type="checkbox"/> PENDING-      <input type="radio"/> For MFS      <input type="radio"/> HCD/ODS referral</p> <p>_____ Initials      _____      Date</p> <p><input type="checkbox"/> RETURNED - _____          _____ Initials      _____      Date</p> <p><input type="checkbox"/> DENIED - _____          _____ Initials      _____      Date</p>	<p align="center"><b>EC</b></p> <p>APPROVED # of days  <input type="checkbox"/> Initial      <input type="checkbox"/> Extension (indicate previous approval)</p> <p>_____ (In numeric)      _____ (In words)</p> <p>_____ (Inclusive Period)</p> <p><input type="checkbox"/> Previous approval _____  <input type="checkbox"/> Hospital (Confined) _____          _____ (Date of Discharge)</p> <p><input type="checkbox"/> PENDING-      <input type="radio"/> For MFS      <input type="radio"/> HCD/ODS referral</p> <p>_____ Initials      _____      Date</p> <p><input type="checkbox"/> RETURNED - _____          _____ Initials      _____      Date</p> <p><input type="checkbox"/> DENIED - _____          _____ Initials      _____      Date</p>
<p>REMARKS _____          _____</p>	<p>REMARKS _____          _____</p>
<p>ILLNESS CODE/S _____</p>	

<p>EVALUATED BY _____</p> <p>_____ SIGNATURE OVER PRINTED NAME      DATE</p>	<p>ENCODED AND RELEASED BY _____</p> <p>_____ SIGNATURE OVER PRINTED NAME      DATE</p>
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**PART IV. PROCESSING CENTER**

<p>FOR INITIAL FILING RECEIVED BY _____</p> <p>_____ SIGNATURE OVER PRINTED NAME      DATE</p>	<p>PROCESSING RESULTS _____</p> <p>PROCESSED AND ENCODED BY _____</p> <p>_____ SIGNATURE OVER PRINTED NAME      DATE</p>
<p>REVIEW RESULTS  <input type="checkbox"/> Approved  <input type="checkbox"/> Rejected  <input type="checkbox"/> Denied</p> <p>REVIEWED BY _____</p> <p>_____ SIGNATURE OVER PRINTED NAME      DATE</p>	<p>CONCURRED BY _____</p> <p>_____ SIGNATURE OVER PRINTED NAME      DATE</p>
<p>FOR RE-FILED CLAIM RECEIVED BY _____</p> <p>_____ SIGNATURE OVER PRINTED NAME      DATE</p>	<p>PROCESSING RESULTS _____</p> <p>PROCESSED AND ENCODED BY _____</p> <p>_____ SIGNATURE OVER PRINTED NAME      DATE</p>
<p>REVIEW RESULTS  <input type="checkbox"/> Approved  <input type="checkbox"/> Rejected  <input type="checkbox"/> Denied</p> <p>REVIEWED BY _____</p> <p>_____ SIGNATURE OVER PRINTED NAME      DATE</p>	<p>CONCURRED BY _____</p> <p>_____ SIGNATURE OVER PRINTED NAME      DATE</p>



# LIST OF FILER'S VALID IDENTIFICATION (ID) CARDS/DOCUMENTS

## Sickness Benefits Process

### A. Primary ID Cards/Documents

1. Social Security (SS) card
2. Unified Multi-Purpose ID (UMID) card
3. Passport
4. Professional Regulation Commission (PRC) card
5. Seaman's Book (Seafarer's Identification & Record Book)

### B. Secondary ID Cards/Documents

1. Alien Certificate of Registration
2. ATM card (with cardholder's name)
3. Bank Account Passbook
4. Company ID card
5. Certificate of Confirmation issued by National Commission on Indigenous People (formerly Office of Southern Cultural Community and Office of Northern Cultural Community)
6. Certificate of Licensure/Qualification Documents from Maritime Industry Authority
7. Certificate of Naturalization
8. Credit card
9. Court Order granting petition for change of name or date of birth
10. Driver's License
11. Firearm License card issued by Philippine National Police (PNP)
12. Fishworker's License issued by Bureau of Fisheries and Aquatic Resources (BFAR)
13. Government Service Insurance System (GSIS) card/Member's Record/Certificate of Membership
14. Health or Medical card
15. Home Development Mutual Fund (Pag-IBIG) Transaction Card/Member's Data Form
16. ID card issued by Local Government Units (LGUs) (e.g. Barangay/Municipality/City)
17. ID card issued by professional association recognized by PRC
18. Life Insurance Policy of member
19. Marriage Contract/Marriage Certificate
20. National Bureau of Investigation (NBI) Clearance
21. Overseas Worker Welfare Administration (OWWA) card
22. Philippine Health Insurance Corporation (PHIC) ID card/Member's Data Record
23. Police Clearance
24. Postal ID card
25. School ID card
26. Seafarer's Registration Certificate issued by Philippine Overseas Employment Administration (POEA)
27. Senior Citizen card
28. Student Permit issued by Land Transportation Office (LTO)
29. Taxpayer's Identification Number (TIN) card
30. Transcript of Records
31. Voter's Identification card/Voter's Affidavit / Certificate of Registration

### 1. Filed by Member

Present original of any one (1) of the **primary** ID cards/documents in **Item A** or two (2) **secondary** ID cards/documents in **Item B** both with signature and at least one (1) with photo.

### 2. Filed by Member's Representative

Present the following:

2.1 Original of any one (1) of the Authorized Representative's **primary** ID cards/documents in **Item A** or two (2) **secondary** ID cards/documents in **Item B** both with signature and at least one (1) with photo; and

2.2 Original of any one (1) of the Member's **primary** ID cards/documents in **Item A** or two (2) **secondary** ID cards/documents in **Item B** both with signature and at least one (1) with photo.