



VPF-01298 (02-2017)

Republic of the Philippines
SOCIAL SECURITY SYSTEM
SSS P.E.S.O. FUND

TOTAL DISABILITY BENEFIT CLAIM FORM

THIS FORM MAY BE REPRODUCED AND IS NOT FOR SALE. THIS CAN ALSO BE DOWNLOADED AT 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 THE MEMBER

A. PERSONAL DATA

SS NUMBER	COMMON REFERENCE NUMBER	DATE OF BIRTH (MM/DD/YYYY)	TAX IDENTIFICATION NUMBER
NAME (LAST NAME)	(FIRST NAME)	(MIDDLE NAME)	(SUFFIX)
GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	CIVIL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Others _____		
ADDRESS IN THE PHILIPPINES (RM./FLR./UNIT NO. & BLDG. NAME) (HOUSE/LOT & BLK. NO.) (STREET NAME)			
(SUBDIVISION)	(BARANGAY/DISTRICT/LOCALITY)	(CITY/MUNICIPALITY)	(PROVINCE)
FOREIGN ADDRESS (IF APPLICABLE)			ZIP CODE
TEL. NO. (AREA CODE + TEL. NO.)			COUNTRY
MOBILE/CELLPHONE NUMBER	E-MAIL ADDRESS		
MEMBERSHIP TYPE <input type="checkbox"/> Employed <input type="checkbox"/> Self-Employed <input type="checkbox"/> Voluntary <input type="checkbox"/> Non-Working Spouse <input type="checkbox"/> Overseas Filipino Worker (OFW)			
BANK NAME/BRANCH		BANK ACCOUNT NO.	

B. BENEFIT PAYMENT OPTION

CHOOSE ONLY ONE (1) OF THE FOLLOWING:

<input type="checkbox"/> LUMP SUM	<input type="checkbox"/> PENSION No. of Monthly Pensions: _____	<input type="checkbox"/> LUMPSUM AND PENSION Lump-sum Amount: _____ No. of Monthly Pensions: _____
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C. BENEFIT CLAIM THROUGH REPRESENTATIVE

I hereby authorize the person whose signature appears below, duly verified by me to file the benefit claim for me.

NAME OF REPRESENTATIVE IN PRINT	SIGNATURE OF REPRESENTATIVE
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D. CERTIFICATION

I certify that the information provided in this form are true and correct. (If member cannot sign, affix fingerprints in the presence of an SSS authorized officer.)

SIGNATURE OF MEMBER

DATE

RIGHT THUMB	RIGHT INDEX
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PART II - TO BE FILLED OUT BY SSS

A. BENEFIT CLAIM INFORMATION

ACCOUNT SUMMARY	AMOUNT	BENEFIT CLAIM
CONTRIBUTIONS		LUMP-SUM AMOUNT:
EARNINGS		
LESS: MANAGEMENT FEES		
TOTAL EQUITY		MONTHLY PENSION AMOUNT:
LESS: WITHDRAWALS		
NET EQUITY		

B. ACTION TAKEN

<input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED <input type="checkbox"/> Findings on identification documents: _____ <input type="checkbox"/> Member is not found to be totally disabled <input type="checkbox"/> With settled SPF Total Disability Claim <input type="checkbox"/> Others: _____	RECEIVED / PROCESSED BY: _____ SIGNATURE OVER PRINTED NAME _____ DATE & TIME
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INSTRUCTIONS

1. Fill out this form in one (1) copy without erasures and alterations.
2. Submit this form to the nearest SSS branch office.
3. Review and confirm the information in the accomplished and printed form provided by the SSS authorized officer by personally affixing signature or thumbmark (if unable to sign) in the presence of an SSS authorized officer.
4. Total disability benefit amount shall be credited to the SPF Member's enrolled bank account in three (3) working days from date of approval.