LIAISON FORM RELATIVE TO THE APPLICATION FOR ..... BENEFIT (1)
Title III, Chapters III, IV and V of the Convention
Articles 7 and 8 of the Administrative Agreement

This form shall be accomplished in that part which affects it, by the Institution at which the application is filed and transmitted, in duplicate copy, to the competent Institution of the other Party. The latter shall return a copy of the form wherein are certified the insurance periods completed under its legislation, to the Institution to which the instruction of the record corresponds, upon request of the same.

Date of filing of the application .....
File reference/no. .....

1. DATA RELATIVE TO THE INSURED PERSON AND HIS/HER SPOUSE

	INSURED PERSON	SPOUSE
– Surnames		
– Name		
– Name of father		
– Name of mother		
– Date of birth		
– Membership number In Spain		
In the Philippines		
– Gender		
– Nationality		
– Civil status (2)		
– National Identity Card Number (3)		
– Date of Marriage		
– Date of death		
– Place of death		
– Cause of death		
– Has he/she been recognized as incapacitated for work? (4)		
– Is he/she working at present?		
– Date at which he/she has stopped working		
– Date at which he/she intends to stop working		
– Does he/she receive or has he/she been receiving any benefit?		
– If affirmative, indicate:		
– Type of benefit		
– Institution that pays it (Name and address)		
– Date of effect		
– Monthly amount of the benefit		
– No. of benefit payments annually		
– Complete home address (5)		

3. DATA OF FAMILY MEMBERS WHO CAN EXERCISE RIGHT TO BENEFITS (6)

SURNAMES AND NAME	Degree of relationship	Date of birth	Lived or lives together with the insured person? (7)	Depended or depends financially on the insured person? (7)	Is disabled to work? (7)	Is working? (7)	Is a pensioner or receives income? (8)

3.1 STATEMENT OF EMPLOYMENT UNDERTAKEN BY THE INSURED PERSON IN SPAIN

NAME OF COMPANY	Address	Period	
		From	To

3.2 STATEMENT OF EMPLOYMENT UNDERTAKEN BY THE INSURED PERSON IN THE PHILIPPINES

NAME OF COMPANY	Address	Period	
		From	To

4. DATA CONCERNING THE INSURANCE PERIODS COVERED BY THE INSURED PERSON

4.1. *To be accomplished by the Institution receiving the application*

INSURANCE PERIODS		CONTRIBUTION PERIODS		EQUIVALENT PERIODS DAYS
FROM	TO	VOLUNTARY DAYS	COMPULSORY DAYS	
TOTALS				

4.2. *To be accomplished by the Institution of the other State*

TOTALS				

5. DETERMINATION OF THE BENEFIT IN THE CHARGE OF SPAIN

Type of benefit	Date of effect	Monthly amount

☐ By totalization ☐ Without totalization

Reasons for which no benefit is paid

6. DETERMINATION OF THE BENEFIT IN THE CHARGE OF THE PHILIPPINES

Type of benefit	Date of effect	Monthly amount

☐ By totalization ☐ Without totalization

Reasons for which no benefit is paid

7. INSTITUTION RECEIVING THE APPLICATION

Name BILATERAL AGREEMENTS DEPARTMENT, SOCIAL SECURITY SYSTEM

Address (5) East Ave., Diliman, Quezon City, PHILIPPINES

Requests the competent Institution of the other Party to ☐ **return** ☐ **not return a copy of this form duly accomplished.**

Seal **Date** .....

Signature

8. INSTITUTION OF THE OTHER PARTY

Name .....

Address (5) .....

.....

Seal **Date** .....

Signature

.....

I N S T R U C T I O N S

This form shall be accomplished typewritten or in block letters, using only the dotted lines.

N O T E S

(1) Write down what may correspond: Old Age, Disability or Survivorship

(2) Indicate as the case may be, single, married, widow(er) or divorced.

(3) For Spanish nationals, indicate the *Documento Nacional de Identidad* (D.N.I.) number - although it may be expired. If he/she does not have it, indicate clearly "does not have it".

(4) Indicate YES or NO, and if affirmative, attach medical report (form E/F - 4) concerning the causes and degree of disability of the cause person and the reasonable possibility of recovery.

(5) Street, number, postal code, locality, province, country.

(6) Children, parents or other rightful claimants.

(7) Indicate YES or NO.

(8) If affirmative, indicate as follows:

- **Nature of the pension.**
- **Paying Institution.**
- **Date at which he/she starts receiving it.**
- **Eventual date of stoppage of its receipt.**
- **Monthly amount of the pension or income.**