AGREEMENT ON SOCIAL SECURITY
BETWEEN
THE REPUBLIC OF THE PHILIPPINES AND THE PORTUGUESE REPUBLIC

APPLICATION FOR BENEFIT

NOTE: This application must be completed by the contributor or, in the case of an application for survivors or death benefit, by the party claiming entitlement to benefits.

PLEASE PRINT

PART A. GENERAL INFORMATION ABOUT THE CONTRIBUTOR

1. Name (Surname, Given Name Middle Name)

2. Social Insurance Number
   a) SS No. _____
   b) GSIS No. _____
   c) Portuguese No. _____

3. Date of birth (MM/DD/YY)

4. Place of birth
   _____
   City or Town/Province State or Territory/Country

5. Address _____ Postal Code

6. Civil Status ☐ Single ☐ Married ☐ Widowed ☐ Separated since _____ Year/Month ☐ Divorced Since _____ Year/Month

7. Is the contributor receiving or has he (she) ever received or applied for benefits under the PH Social Security Law and/or the Government Service Insurance Act?

   ☐ yes ☐ SSS ☐ no
   ☐ GSIS
   ☐ SSS & GSIS

   If "yes", what type of benefit? (retirement, total/partial disability?) _____

8. Has the contributor ever paid contributions to a social security plan in a country other than the Philippines?

   ☐ yes ☐ no

   If "yes" in what country or countries? _____

9. Qualified dependent children

   Indicate the first and last names, and date of birth of each legitimate, legitimated, or legally adopted child who is unmarried, not gainfully employed, and not over 21 years of age, or over 21 years of age, provided that he is congenitally incapacitated and incapable of self-support physically or mentally, but not exceeding five, beginning with the youngest and without substitution.

First Name	Last Name	Date of Birth			Address
		Year	Month	Day	

10. Employment History

Employer	Period of Employment		Address
	From	To	

If there is not enough space, please add a separate sheet giving the required information.

PART B. APPLICATION FOR A RETIREMENT PENSION (Be sure you have completed PART A). You must be at least 60 years old and separated from employment.

If you are between 60 and 65 years of age, have you stopped working?

☐ yes, I have stopped working on: _____ year/month

☐ no, I am still working.

☐ no, I will stop working on: _____ year/month

PART C. APPLICATION FOR THE DISABILITY AND DEPENDENT'S PENSION (Be sure you have completed PART A)

1. Exact date on which your disability began: _____ year/month/day

2. Have you been previously granted disability benefits?

☐ yes Dates: _____

☐ no

3. Have you stopped working completely?

☐ yes If "yes", when did you stop? _____ year/month/day

For what reasons? _____

☐ no If "no", are you working regularly? ☐ or occassionally? ☐

4. Information about your last job?

Name of last employer: _____

Period of employment: from _____ year/month/day to _____ year/month/day

What position did you hold? Describe your job

Did you have to work outdoors? Why did you leave this job?

☐ yes ☐ no

5. Are you in a hospital or confined in an institution? ☐ yes ☐ no

If "yes", give details:

_____ Name of Hospital or Institution _____ Address _____ Tel. no.

6. Who is the physician best able to provide the Social Security System/ and or the Government Service Insurance System about your disability?

Physician's name _____

Physician's address _____ Tel. no.: _____

_____

7. Who are the other physician(s) you have consulted about your disability?

Physician's name	Address	Tel. No.	Approximate	
			year	month

8. In what medical establishments were you treated or examined? (out-patient)

Name of establishment	Address	Tel. No.	Approximate	
			year	month

Information about the person completing the application on behalf of the disabled person.

☐ Mr.
☐ Mrs.
☐ Miss

_____ _____ _____

Surname First Name Relationship to disabled person

Address: _____ Postal Code: _____ Tel. No. _____

_____

PLEASE ENCLOSE A MEDICAL REPORT WITH THE APPLICATION FOR DISABILTY PENSION.

PART D. APPLICATION FOR THE SURVIVING SPOUSE AND DEPENDENT'S PENSION (Be sure you have completed PART A)

1. Information about the deceased:

a) Date of death _____ b) Place of death _____

year/month/day City or Town/Province, State or Territory/Country

2. Information about the surviving spouse: _____

First and last names you are now using

3. Your first and last names at birth ☐ the same or _____

4. Address of your permanent residence at the time of the contributor's death

_____ Postal Code _____

_____

5. Your current address (if different from than shown above)

_____ Postal Code _____

_____

6. Your date of birth _____ (year/month/day)

7. Your place of birth _____ (City or Town/Province, State or Territory/Country)

8. Were you married to the contributor at the time of his/her death?

☐ Yes If "yes" give date and place of marriage _____ (year/month/day) _____ (Place of Marriage)

☐ No If "no" since when have you been living with the contributor? _____ (year/month/day)

Did any children result from your union with the contributor? ☐ Yes ☐ No

9. Surviving descendants other than those enumerated under Question No. 9 Part A.

Illegitimate minor Children (acknowledged natural and other illegitimate children)

Surname	First Name	Date of birth			Address
		Year	Month	Day	(If minor, give name, address and relationship of guardian)

10. Surviving ascendants (Do not complete if deceased is survived by legitimate minor children.)

Parents of Deceased

Surname	First Name	Address

11. Surviving Collateral Relatives of Decedent (Do not completer if deceased is survived by ascendants or descendants)

Brothers and Sisters of Deceased

Name	Date of birth			Address	Remarks
	Year	Month	Day	(If minor, give name, address and relationship of guardian)	(state whether full-blood or half-blood)

12. Other relatives within the 6th civil degree (Do not complete if deceased has living relatives under items 9 to 11.)

Name	Date of birth			Address	Remarks
	Year	Month	Day	(If minor, give name, address and relationship of guardian)	(state whether full-blood or half-blood)

PART E. DECLARATION OF THE APPLICANT	***Declaration of witness where the applicant has signed***
I hereby apply, under the PH Social Security and/or Government Service Insurance System, for the benefits indicated above. I declare that, to the best of my knowledge, the information provided in this application is true and complete and I undertake to notify the Social Security System and/or Government Service Insurance System Signature: _____ Date: _____ year/month/day	I have read this application to the applicant, who appears to understand the contents and has signed with a cross (X). _____ First Name and Surname of Witness Signature of Witness Address of Witness _____ _____

AUTHORIZATION TO TRANSMIT PERSONAL INFORMATION AND TO DIVULGE MEDICAL INFORMATION

For the purpose of this application made under the legislation of the Philippines, I authorize the _____ to transmit to the liaison agency and to the competent institution of the Philippines, designated in the Administrative Arrangement for the Application of the Agreement on Social Security between the Government of Philippines and the Government of Portuguese Republic, any information concerning the SSS and/or GSIS decision, except for any information concerning my claim for Philippine social insurance benefit.

Signature: _____ Date: _____

TO BE COMPLETED BY THE COMPETENT INSITUTION OF PORTUGAL

Date on which application was received _____ year/month/day

Information about the contributor

Date of Birth	Date of Death	Date of Marriage	Date of Separation/Divorce
_____ year/month/day	_____ year/month/day	_____ year/month/day	_____ year/month/day
☐ verified	☐ verified	☐ verified	☐ verified

Information about the surviving spouse

Date of birth _____ year/month/day ☐ verified

Information about the qualified dependent children

NAME	DATE OF BIRTH	
		☐ verified
		☐ verified
		☐ verified
		☐ verified
		☐ verified

I hereby declare that the information concerning civil status given in this form was taken from original documents provided by the applicant.

Name of Office: _____

Date	Signature	Official seal/stamp