Republic of the Philippines

SOCIAL SECURITY SYSTEM

SSS P.E.S.O. FUND

TOTAL DISABILITY BENEFIT CLAIM FORM

VPF-01298 (02-2017)

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 ☐ Male ☐ Female

CIVIL STATUS ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Others _____

ADDRESS IN THE PHILIPPINES (RM./FLR./UNIT NO. & BLDG. NAME) (HOUSE/LOT & BLK. NO.) (STREET NAME)

(SUBDIVISION) (BARANGAY/DISTRICT/LOCALITY) (CITY/MUNICIPALITY) (PROVINCE) ZIP CODE

FOREIGN ADDRESS (IF APPLICABLE) COUNTRY

TEL. NO. (AREA CODE + TEL. NO.) MOBILE/CELLPHONE NUMBER E-MAIL ADDRESS

MEMBERSHIP TYPE

☐ Employed ☐ Self-Employed ☐ Voluntary ☐ Non-Working Spouse ☐ Overseas Filipino Worker (OFW)

BANK NAME/BRANCH BANK ACCOUNT NO.

B. BENEFIT PAYMENT OPTION

CHOOSE ONLY ONE (1) OF THE FOLLOWING:

☐ LUMP SUM

☐ PENSION
No. of Monthly Pensions

☐ LUMPSUM AND PENSION
Lump-sum Amount:
No. of Monthly Pensions:

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

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

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

☐ APPROVED

☐ DISAPPROVED
- ☐ Findings on identification documents: _____
- ☐ Member is not found to be totally disabled
- ☐ With settled SPF Total Disability Claim
- ☐ Others: _____

RECEIVED / PROCESSED BY:

SIGNATURE OVER PRINTED NAME

DATE & TIME

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.