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

**A. PERSONAL DATA**

<table>
<thead>
<tr>
<th>SS NUMBER</th>
<th>COMMON REFERENCE NUMBER (IF ANY)</th>
<th>DATE OF BIRTH (MMDDYYYY)</th>
<th>TAX IDENTIFICATION NUMBER (IF ANY)</th>
</tr>
</thead>
</table>

**NAME**

- LAST NAME
- FIRST NAME
- MIDDLE NAME
- SUFFIX

**LOCAL ADDRESS**

- (RM/FLOOR NO. & BLDG. NAME)
- (HOUSE/LOT & BLK. NO.)
- (STREET NAME)

- (SUBDIVISION)
- (BARANGAY/DISTRICT/LOCALITY)
- (CITY/MUNICIPALITY)
- (PROVINCE)

- ZIP CODE

**TELEPHONE NUMBER**

- (AREA CODE + TEL. NO.)

**MOBILE/CELLPHONE NUMBER**

**E-MAIL ADDRESS**

**FOREIGN ADDRESS (IF APPLICABLE)**

- COUNTRY
- ZIP CODE

**B. 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. 4 of the form.

Below are the witnesses to fingerprinting:

1. **PRINTED NAME**

   **SIGNATURE**

   **DATE**

2. **PRINTED NAME**

   **SIGNATURE**

   **DATE**

   **RIGHT THUMB**

   **RIGHT INDEX**

**PART II - TO BE FILLED OUT BY EMPLOYER**

**A. EMPLOYER DATA**

<table>
<thead>
<tr>
<th>EMPLOYER NUMBER</th>
<th>TAX IDENTIFICATION NUMBER (IF ANY)</th>
<th>TYPE OF EMPLOYER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Business ☐</td>
</tr>
</tbody>
</table>

**EMPLOYER NAME**

**EMPLOYER ADDRESS**

- (RM/FLOOR NO. & BLDG. NAME)
- (HOUSE/LOT & BLK. NO.)
- (STREET NAME)

- (SUBDIVISION)
- (BARANGAY/DISTRICT/LOCALITY)
- (CITY/MUNICIPALITY)
- (PROVINCE)

- ZIP CODE

**TELEPHONE NUMBER**

- (AREA CODE + TEL. NO.)

**E-MAIL ADDRESS**

**WEBSITE**

**FOR BUSINESS EMPLOYER**

**B. ACCIDENT/SICKNESS REPORT**

**PERIOD OF EMPLOYMENT**

From (MMDDYYYY) To (MMDDYYYY)

**WORKING HOURS**

Regular: From (A.M./P.M.) To (A.M./P.M.)

Overtime: From (A.M./P.M.) To (A.M./P.M.)

**OCCUPATION**

**JOB DESCRIPTION** (STATE BRIEF DESCRIPTION OF DUTIES. SPECIFY NAME OF CHEMICALS OR SUBSTANCE TO WHICH THE EMPLOYEE IS EXPOSED, IF ANY. USE SEPARATE SHEET(S), IF NECESSARY.)

**DATE OF ACCIDENT/SICKNESS**

(MMDDYYYY)

**TIME OF ACCIDENT**

A.M. ☐

P.M. ☐

**PLACE OF ACCIDENT**

**DESCRIPTION OF ACCIDENT/SICKNESS**

(IF VEHICULAR ACCIDENT, STATE PURPOSE OF TRIP. USE SEPARATE SHEET(S), IF NECESSARY.)

**C. CERTIFICATION**

I certify that the information provided in this form are true and correct and that the reported accident/sickness is duly documented in the company record.

**PRINTED NAME OF IMMEDIATE SUPERVISOR**

**SIGNATURE OF IMMEDIATE SUPERVISOR**

**POSITION TITLE**

**DATE**

**PRINTED NAME OF MANAGER**

**SIGNATURE OF MANAGER**

**POSITION TITLE**

**DATE**

Perforate Here ...

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Republic of the Philippines

SOCIAL SECURITY SYSTEM

EC MEDICAL REIMBURSEMENT APPLICATION

ACKNOWLEDGEMENT STUB

<table>
<thead>
<tr>
<th>SS NUMBER/COMMON REFERENCE NO. (IF ANY)</th>
<th>NAME</th>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MIDDLE NAME</th>
<th>SUFFIX</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>RECEIVED BY</th>
<th>SIGNATURE OVER PRINTED NAME</th>
<th>POSITION TITLE</th>
<th>DATE &amp; TIME</th>
<th>BRANCH</th>
</tr>
</thead>
</table>

Republic of the Philippines

SOCIAL SECURITY SYSTEM

EC MEDICAL REIMBURSEMENT APPLICATION

ACKNOWLEDGEMENT STUB

**SIGNATURE OVER PRINTED NAME**

**POSITION TITLE**

**DATE & TIME**

**BRANCH**

---

This form may be reproduced and is not for sale. This can also be downloaded thru the SSS website at www.sss.gov.ph.
### PART III - TO BE FILLED OUT BY SSS

#### A. SCREENING RESULTS

<table>
<thead>
<tr>
<th>FINDINGS</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ With previously approved EC/Sickness Claim for the same case</td>
<td>☐ With deficiency/discrepancy noted, please see attached Medical Claims Compliance Letter</td>
<td>☐ In order, may proceed to Medical Evaluation</td>
<td></td>
</tr>
</tbody>
</table>

**Claim Reference Number**

**RECEIVED AND SCREENED BY**

<table>
<thead>
<tr>
<th>SIGNATURE OVER PRINTED NAME</th>
<th>DATE &amp; TIME</th>
<th>BRANCH</th>
</tr>
</thead>
</table>

**B. MEDICAL EVALUATION**

<table>
<thead>
<tr>
<th>LOGGED BY</th>
<th>EVALUATED BY</th>
<th>REVIEWED BY</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIGNATURE OVER PRINTED NAME</td>
<td>DATE &amp; TIME</td>
<td>SIGNATURE OVER PRINTED NAME</td>
</tr>
</tbody>
</table>

**REMARKS**

**PROCESSED AND ENCODED BY**

| SIGNATURE OVER PRINTED NAME | DATE & TIME | | |
|---|---|---|

**C. PROCESSING**

<table>
<thead>
<tr>
<th>REVIEWED BY</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIGNATURE OVER PRINTED NAME</td>
</tr>
</tbody>
</table>

**D. POST-PROCESSING (IF WITH POSSIBLE ER LIABILITY)**

<table>
<thead>
<tr>
<th>REVIEWED BY</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIGNATURE OVER PRINTED NAME</td>
</tr>
</tbody>
</table>

**REMARKS**

**PROCESSED BY**

| SIGNATURE OVER PRINTED NAME | DATE & TIME | | |
|---|---|---|

### 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. Present valid identification cards/documents. Refer to attached "List of FIler's Valid Identification (ID) Cards/Documents."
4. If a 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-B.
   - Filed by authorized representative/employer/employer's representative/company representative
     - Two (2) witnesses. One (1) witness is the authorized representative/employer/employer's representative/company representative himself 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-B.
5. Submit the following documentary requirements, whichever is applicable, to the nearest SSS branch office:

#### BASIC DOCUMENTS

- a. Properly accomplished EC Medical Reimbursement Application Forms 1 & 2
- b. Photocopy of page in the company record or any proof containing the description/information of the sickness/accident
- c. Accident Report
- d. Other documents

For work-related sickness/illness
- Pre-employment physical examination report; Chest X-ray; ECG, if available
- Certificate of Length of Service certified by employer; and
- Certified true copy of hospital abstract

#### ADDITIONAL SUPPORTING DOCUMENTS

- For Employer/Member Payee
  - a. Original official Receipt/s (OR) with BIR permit number of medical expenses including professional fees. If the absence of the original copies of OR which are in custody of PhilHealth or any Health Maintenance Organization (HMO), the medical expenses may be proved by photocopies of OR stamped with "certified true copy" by the PhilHealth official or HMO authorized representative in custody of the OR.
  - b. Original copy of charge slips/statement of accounts with itemized list or breakdown of expenses
- For Hospital/Clinic Payee/Provider
  - a. Original copy of charge slips/statement of accounts with itemized list or breakdown of expenses
- For Doctor Payee
  - a. Clinical records showing the following:
    - Services rendered
    - Number and dates of consultation/s or visit/s, if hospitalized
  - b. Operating Room Record, if applicable
6. Use another sheet of Form 2, if there are more than three (3) payees/claimants.

If employee is deceased, the person who signed the application should indicate his/her relationship to the employee beside his/her name.

7. This form can be downloaded thru the SSS website at www.sss.gov.ph.

### REMINDER

EC Medical Reimbursement Application should be filed within three (3) years from date of sickness/accident.

### WARNING

ANY PERSON WHO MAKES ANY FALSE STATEMENT IN THIS APPLICATION OR SUBMITS ANY FALSIFIED DOCUMENT IN CONNECTION WITH THIS CLAIM SHALL BE LIABLE CRIMINALLY UNDER SECTION 28 OF R.A. 8282 OR UNDER PERTINENT PROVISION OF THE REVISED PENAL CODE OF THE PHILIPPINES.