

Republic of the Philippines

SOCIAL SECURITY SYSTEM MATERNITY BENEFIT APPLICATION/

MATERNITY BENEFIT REIMBURSEMENT APPLICATION (FOR SPECIAL CASES)

THIS FORM MAY BE REPRODUCED AND IS NOT FOR SALE. THIS CAN ALSO BE DOWNLOADED THRU 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.

| PART I - TO BE FILLED OUT BY PAYEE | | | | |
|---|---|--|----------------------|--|
| TYPE OF SPECIAL CASE | | | | |
| ☐ Denied claim reconsidered for payment ☐ Ur | nclaimed benefit of deceased member Unclaim employe | ed reimbursement of inactive/closed/tern er | ninated/retired | |
| | A. MEMBER'S DATA | | | |
| SS NUMBER COMMON | REFERENCE NUMBER (IF ANY) DATE OF BI | RTH (MMDDYYYY) TAXPAYER ID NU | JMBER (IF ANY) | |
| | <u> </u> | <u> </u> | | |
| NAME (LAST NAME) | (FIRST NAME) | | (SUFFIX) | |
| MAILING ADDRESS (RM/FLR/UNIT NO. & BLI | DG. NAME) (HOUSE/LOT & BLK. NO.) | (STREET NAME) | | |
| (SUBDIVISION) (BARANGAY/DI | ISTRICT/LOCALITY) (CITY/MUNICIPALITY) | (PROVINCE) | POSTAL CODE | |
| TELEPHONE NUMBER (AREA CODE + TEL. NO.) MOBIL | E-MAIL ADD | PRESS | | |
| FOREIGN ADDRESS (IF APPLICABLE) | | COUNTRY | DOOTAL CODE | |
| FOREIGN ADDRESS (IF APPLICABLE) | | COUNTRY | POSTAL CODE | |
| DELIVERY TYPE | | DATE OF DELIVERY/MISCARRIAG | PE/ETD (MM/DD/YYYY) | |
| | /Emergency Termination of Pregnancy (ETP) | DATE OF DELIVERTIMISOARRIAG | JE/EIF (WWW,DD/IIII) | |
| | c Pregnancy | | | |
| | diform Mole | | | |
| Stillbirth/Fetal Death | | | | |
| NUMBER OF PREGNANCY NUMBER OF | OF ALLOCATED MATERNITY LEAVE CREDITS (0-7) | MEMBER IS SOLO PARENT? | | |
| | | Yes No | | |
| | B. PAYEE'S DATA | | | |
| TYPE OF PAYEE | | | | |
| Member (For member-payee, do not fill out data below.) | Employer Child's Father Alternate Car | regiver Member's Ben | neficiary/Legal Heir | |
| SS NUMBER/EMPLOYER ID NUMBER | NAME | | | |
| | | (| | |
| MAILING ADDRESS (RM./FLR./UNIT NO. & BL | DG. NAME) (HOUSE/LOT & BLK. NO.) | (STREET NAME) | | |
| (OLIDON (OSAN) (DADANCAY/DI | (CITY/MINICIPALITY | (DDQ)/IN(CE) | | |
| (SUBDIVISION) (BARANGAY/DI | ISTRICT/LOCALITY) (CITY/MUNICIPALITY) | (PROVINCE) | POSTAL CODE | |
| TELEPHONE NUMBER (AREA CODE + TEL. NO.) E-MAIL | L ADDRESS | ANACHINIT EOD DEIMBLIDGEMENT (EO | D EMDLOVED) | |
| TELEPHONE NUMBER (AREA SOSE TELEMO) | _ ADDRESS | AMOUNT FOR REIMBURSEMENT (FO | R EMPLOTER) | |
| | | | | |
| | C. CERTIFICATION | | | |
| I certify that: | | | | |
| | prrect and I understand that I shall be held liable | under all circumstances for any fal | se information, | |
| misrepresentation, and fraud in this application. | | | | |
| b. I authorize SSS to use my information to process my application for maternity benefit including verification from the source of such information | | | | |
| and for the establishment, exercise or defense of SSS legal claims against me in case I commit fraud in the submission of this application. c. I agree that the information collected through this form shall be used and retained by the SSS for the processing of the maternity benefit. | | | | |
| | ugh this form shall be used and retained by the Sinding to the period not allocated was advanced to | | y benefit. | |
| d. The amount of maternity benefit correspor | liding to the period flot allocated was advanced to | the employee (for employers ormy). | | |
| | | | | |
| PRINTED NAME OF PAYEE | SIGNATURE POSITIO | ON TITLE (FOR EMPLOYER ONLY) | DATE | |
| | | , | | |
| If payee cannot sign, affix fingerprints. Please read | instruction no. 6 of this form. | | | |
| | Witnesses to fingerprinting: | | | |
| | 1) | | | |
| | PRINTED NAME | SIGNATURE | DATE | |
| | 2) | | | |
| RIGHT THUMB RIGHT INDEX | PRINTED NAME | SIGNATURE | DATE | |

| SS NUMBER OF MEMB | FR | NAME OF MEMBER | | | |
|--|--|--------------------------------------|-------------------------|----------------------------------|--|
| I I I I | | NAME OF MEMBER | | | |
| | | | | | |
| | | PART II - TO I | BE FILLED OUT BY S | SS | |
| | | A. BRANCH/FOREIGN OFF | ICE/MEDICAL EVALU | JATION CENTER | |
| SCREENING AND REC | EIVING RESULTS | | | REMARKS | |
| ID/s Presented by filer | | | | | |
| UMID/SS Card | PhillD | ☐ Valid ID Card/s or Document/ | s 🗌 None | | |
| Form Accomplishment | | | | | |
| ☐ Complete | ☐ Incomplete (| (see remarks) | | | |
| Documents Submitted | | | | | |
| ☐ Complete | ☐ Incomplete | (see remarks) For ver | ification (see remarks) | | _ |
| Eligibility Result | | | | | |
| Qualified | ■ Not Qualified | d/With discrepancy/ies (see remarks) |) | | DATE RETURNED |
| SCREENED AND RECE | IVED BY | | | | |
| | | | | | |
| | | | | | |
| SIGNAT | URE OVER PRIN | ΓED NAME | POSITION | TITLE | DATE & TIME |
| В | . MEDICAL EVA | LUATION CENTER (FOR MISC | CARRIAGE/ETP/ECT | OPIC PREGNANCY/H | I-MOLE CASES) |
| RECOMMENDATION | | | | | |
| | ate of contingency: | | | ied - Not compensable b | ased on medical supporting document/s. |
| | | pregnancy without operation and h | H-mole) | | |
| Ectopic pregnar | | | □ p | dia a | |
| Returned for Compliance | | | ☐ Pen | oing For medical/legal opinio | 0 |
| ☐ Submit D & C report☐ Submit complete OB History issued by attending physician | | | For PRC Verification | | |
| | For interview & present UMID/SS Card/PhilID or Valid ID Card/s or Document/s | | | | |
| EVALUATED BY | | | | | |
| | | | | | |
| | | | | | |
| SIGNAT | URE OVER PRIN | ΓED NAME | POSITION | TITLE | DATE & TIME |
| REVIEWED BY | | | | | |
| | | | | | |
| | | | | | |
| | URE OVER PRINT | red name | POSITION | TITLE | DATE & TIME |
| REMARKS, IF ANY | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

INSTRUCTIONS

- 1. Fill out this form in two (2) copies.
- In case of multiple legal heirs, fill out two (2) copies of this form for each legal heir.
- 3. Always indicate "N/A' or "Not Applicable", if the required data is not applicable.
- 4. Affix initials on all alterations/erasures in this form.
- 5. Always indicate e-mail address or mobile/cellphone number.
- 6. If the payee cannot sign, there should be two (2) witnesses to fingerprinting.
 7. Submit this form to the nearest SSS branch/foreign office together with together with the complete identification and documentary requirements based on the Identification and Documentary Requirements Guide.

| | | | N AND DOCUMENTARY REQUIREMENTS GUIDE |
|----|--|-------------------------------|--|
| | | I. IDENT | IFICATION REQUIREMENTS CHECKLIST |
| | ID CARRE/DOCUMENTS | TYPE OF EU ED | IDENTIFICATION REQUIREMENTS |
| | ID CARDS/DOCUMENTS | TYPE OF FILER | (SSS Personnel to check appropriate box of each ID card/document presented/submitted and |
| _ | Primary ID card/document [any one | 1. Member | write any remarks, if necessary) Present original copy of the following: (Please specify) |
| Α. | (1) of the following]: | i. Wember | |
| | · · · · · · · · · · · · · · · · · · · | | One (1) Primary ID card/document OR two (2) Secondary ID cards/documents [both wi signature and at least one (1) with photo] of the member |
| | •••••••••••••••••••••••••••••••••••••• | | signature and at least one (1) with photoj of the <u>internber</u> |
| | Social Security Card Dhilipping Identification Cord | O Childle fother/ | Descent spining some of the fellowings (Please specific) |
| | Philippine Identification Card Alian Cartificate of Registration | Child's father/ Alternate | Present original copy of the following: (Please specify) |
| | Alien Certificate of Registration Driverto Licenses | Caregiver/ | a. One (1) Primary ID card/document OR two (2) Secondary ID cards/documents [both wi |
| | 5. Driver's License | Benefiiciary/ | signature and at least one (1) with photo] of the member |
| | 6. Firearm Registration | Legal Heir | |
| | 7. License to Own and Possess | Ŭ | b. One (1) Primary ID card/document OR two (2) Secondary ID cards/documents [both with |
| | Firearms | | signature and at least one (1) with photo] of the child's father/alternate |
| | 8. National Bureau of Investigation | | caregiver/beneficiary/legal heir |
| | (NBI) Clearance | 0 5 1 | |
| | 9. Passport | 3. Employer | Present original copy of the following: (Please specify) |
| | 10. Permit to Carry Firearms Outside | (authorized signatory) | One (1) Primary ID card/document OR two (2) Secondary ID cards/documents [both wi |
| | of Residence | Signatory) | signature and at least one (1) with photo] of the <u>employer</u> |
| | 11. Postal Identity Card | | |
| | 12. Searfarer's Identification & Record | | Present original copy of the following: (Please specify) |
| | Book (Seaman's Book) | representative of member/ | |
| | 13. Voter's ID Card | employer | signature and at least one (1) with photo] of the member/employer |
| | | 1 | |
| В. | Any two (2) other ID | | b. One (1) Primary ID card/document OR two (2) Secondary ID cards/documents [both wi |
| | cards/documents, both with | | signature and at least one (1) with photo] of the authorized representative |
| | signature and at least one (1) with | | |
| | photo (in the absence of a primary | | Submit original copy of: |
| | ID card/document). Please specify. | | c. Letter of Authority |
| | | 5. Authorized | Present original copy of the following: (Please specify) |
| | | representative of | a. One (1) Primary ID card/document OR two (2) Secondary ID cards/documents [both wi |
| | | Child's father/ | signature and at least one (1) with photo] of the member |
| | | Alternate | digitation and at loads one (1) that photogor and internsor |
| | | Caregiver/ | b. One (1) Primary ID card/document OR two (2) Secondary ID cards/documents [both wi |
| | | Beneficiary/ | b. One (1) Primary ID card/document OR two (2) Secondary ID cards/documents [both will signature and at least one (1) with photol of the child's father/alterna |
| | | Legal Heir | caregiver/beneficiary/legal heir |
| | | | an og ronnen grogarnen |
| | | | c. One (1) Primary ID card/document OR two (2) Secondary ID cards/documents [both wi |
| | | | c. One (1) Primary ID card/document OR two (2) Secondary ID cards/documents [both will signature and at least one (1) with photo] of the authorized representative |
| | | | Signature and at least one (1) wan photo] of the authorized representative |
| | | | Submit original copy of: |
| | | | d. Letter of Authority |
| | IL DOCUMENTARY RE | QUIREMENTS CHE | CKLIST - Present original/certified true copy/ies and submit photocopy/ies |
| | | | e box of each document submitted and write any remarks, if necessary) |
| Α. | Documents depending on delivery ty | | |
| | 1. For Live Childbirth regardless if | via normal or caesa | rian section (CS) 3.2 Proof of Termination of Pregnancy duly signed by a physician [Al |
| | delivery [Any one (1) of the following | ng] | one (1) of the following] |
| | Child's Certificate of Live Birth | | , , |
| | the Local Civil Registrar (LC | | |
| | (OR) or Acknowldegement Re | | |
| | date of maternity benefit | , | |
| | reimbursement application (M | BRA) IS WITHIN SIX (6) | |
| | of delivery | inth/O-mifficults of De- | following] |
| | Child's Certificate of Live Bi | | |
| | Philippine Statistics Authority filing date of MBA/MBRA is | | 7, *, · · · · · · · · · · · · · · · |
| | delivery | beyond six (o) mor | ths from date of Clinical Abstract/Discharge Summary Notes: |
| | Report of Child's Birth/ | Death issued by | the Philippine For maternity contingencies that occurred locally: |
| | Embassy/Consulate General/F | | |
| | in a foreign country with Englis | · | · · · · · · · · · · · · · · · · · · · |
| | 2. For Stillbirth/Fetal Death [Any one | | - Physician's name and Professional Regulation Commission licens |
| | Certificate of Fetal Death | • • | · · · · · · · · · · · · · · · · · · · |
| | corresponging OR or AR is | | |
| | MBA/MBRA is within six (6) me | onths from date of deli | very - Medical documents issued in a foreign country must be submitted |
| | Certificate of Fetal Death issue | ed by the PSA with cor | responding OR or with English translation, if applicable |
| | AR, if filing date of MBA/MBR | A is beyond six (6) mo | onths from date of B. Documents depending on specific maternity case/circumstance |
| | delivery | | For Solo Parent [Any one (1) of the following] |
| | Certificate of Fetal Death issue | | • |
| | General/PSA, or its equivalen | | |
| | with English translation, if appl | | Certification/e-Certification of eligibility of the Solo Parent issued I |
| | 3. For Miscarriage/Emergency | | |
| | [including Ectopic Pregnancy/Hy | - | ID is not yet available |
| | 3.1 Proof of Pregnancy [Any one (| | Notes: The data of delivery must be within the validity period of the Se |
| | Result of pregnancy test health officer | udiy signed by the p | nysician/municipal - The date of delivery must be within the validity period of the So Parent ID/Certification/e-Certification of Eligibility, except for first-tim |
| | Result of diagnostic tests | with corresponding | |
| | by a physician which may | | |
| | - Ultrasound | Judge drift of the follo | - Certification/e-Certification of eligibility must contain all the necessa |
| | - Blood Pregnancy test | (Beta HCG) | details as reflected in the Solo Parent ID |
| | - Early Pregnancy factor | | |
| | , | | |
| | | | |

| | | | original/certified true copy/ies and submit photocopy/ies |
|--|--|---|--|
| 2. For Self-employed/Voluntary Men Worker (OFW) member who was preseparated from employment 2.1 If the delivery/miscarriage/ETP or or within six (6) months date of segment of the months date of separation and that not the employer 2.2 If member cannot secure Certificated Affidavit of Undertaking, duly official/employee/foreign administering officer, indicating employer (original copy) 3. For Employer who already paid the the employee but cannot provide reconstructions. | curs within the employment period paration from employment Employment indicating the effective of advance payment was granted by the of Separation of Employment administered by the SSS branch representative authorized as an effective date of separation from ance payment was granted by the ematernity benefit in advance to quired documents since employee | 5. F fc d d C C C C C C C C C C C C C C C C C | brmitted and write any remarks, if necessary) For CS delivery that occurred before March 11, 2019 [Any one (1) of the following issued by the hospital/medical facility indicating the type of lelivery] Operating Room Record Surgical Memorandum Discharge Summary Report Medical/Clinical Abstract Delivery Report Detailed invoice showing CS charges (for deliveries abroad only) Similar medical documents which indicate the type of contingency For unclaimed benefit of a deceased member 6.1 For contingency that occurred on or after March 11, 2019 Affidavit of Undertaking of the child's father/alternate caregiver, duly administered by the SSS branch official/employee/foreign representative authorized as administering officer (original copy) |
| employee is already separated employee's Certificate of Death iss 3.3 Proof of advance payment by to following]: Cash voucher or relevant doc payment signed by the memb Proof of credit or transfer to | by the hospital/medical facility e/ETP; or proof of pregnancy that the employee did not return or dbirth/miscarriage/ETP or that the from employment; or deceased sued by the PSA/LCR the employer [Any one (1) of the lument indicating receipt of advance | 6 | 5.2 For contingency that occurred before March 11, 2019 Affidavit of Undertaking of the member's beneficiary/legal heir, duly administered by the SSS branch official/employee/foreign representative authorized as administering officer (original copy) |
| caregiver stating that he/she the period of maternity leave 4.2 If date of separation is prior to the Certificate of Separation f employer of the child's fathe effective date of separation 4.3 If date of separation is after the da Certificate/s issued by the em caregiver indicating the effect | he period of maternity leave hed by the child'd father/alternate is unemployed prior to and during date of delivery of the member rom Employment issued by the er/alternate caregiver indicating the | | |