Republic of the Philippines
SOCIAL SECURITY SYSTEM

SICKNESS NOTIFICATION

SIC - 01252 (12-2015)

CLAIM NO. _____ **RE-FILING CLAIM NO.** _____

THIS FORM MAY BE REPRODUCED AN IS NOT FOR SALE. THIS CAN ALSO BE DOWNLOADED THRU THE SSS WEBSITE AT www.sss.gov.ph

PLEASE READ THE INSTRUCTIONS AND REMINDER 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 (IF ANY) | DATE OF BIRTH (MMDDYYYY) | TAX IDENTIFICATION NUMBER (IF ANY)

NAME (LAST NAME) (FIRST NAME) (MIDDLE NAME) (SUFFIX)

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

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

TELEPHONE NO. (AREA CODE + TEL NO.) | MOBILE/CELLPHONE NO. | 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. 6 of the form.
Below are the witnesses to fingerprinting:

1) PRINTED NAME _____ SIGNATURE _____ DATE _____
ADDRESS & CONTACT NUMBER _____

2) PRINTED NAME _____ SIGNATURE _____ DATE _____
ADDRESS & CONTACT NUMBER _____

RIGHT THUMB | RIGHT INDEX

PART II - TO BE FILLED OUT BY EMPLOYER

A. EMPLOYER DATA

EMPLOYER ID NUMBER | NAME OF EMPLOYER/REGISTERED BUSINESS NAME | E-MAIL ADDRESS

BUSINESS ADDRESS (NO. & STREET) (BARANGAY) (TOWN/ DISTRICT) (CITY/PROVINCE) ZIP CODE

START OF SICK LEAVE (MMDDYYYY) | NOTIFICATION FORM WAS RECEIVED BY US ON (MMDDYYYY) | E-NOTIFICATION DATE (MMDDYYYY) | ACCIDENT/SICKNESS OCCURRED WHILE ☐ Working ☐ In Co. Premises ☐ On Vacation ☐ On Strike ☐ Co. Shutdown ☐ Under Suspension

B. CERTIFICATION

I certify that the above information are true and correct and that the reported accident/illness is duly recorded in the Employer's Logbook for EC Claim under page number _____ and entry number _____.

SIGNATURE OVER PRINTED NAME EMPLOYER/AUTHORIZED REPRESENTATIVE _____ OFFICIAL DESIGNATION _____ DATE _____

PART III - MEDICAL CERTIFICATE (TO BE FILLED OUT BY THE ATTENDING PHYSICIAN)

BRIEF MEDICAL HISTORY AND PERTINENT FINDINGS

ATTENDING PHYSICIAN'S CERTIFICATION

I certify that I have seen and examined above-named patient on _____ (DATE) and in my opinion, confinement including recuperation period may last _____ (no. of days) days.

DIAGNOSIS: _____ FIT TO WORK: _____

PLACE OF CONFINEMENT ☐ HOME ☐ HOSPITAL | START OF CONFINEMENT (MMDDYYYY) | NAME OF HOSPITAL (if confined in a hospital)

PRINTED NAME AND SIGNATURE | LICENSE NO.

ADDRESS OF PHYSICIAN'S CLINIC/HOSPITAL (NO. & STREET) (BARANGAY) (TOWN/ DISTRICT) (CITY/PROVINCE) ZIP CODE

PART IV - TO BE FILLED OUT BY SSS PERSONNEL

RECEIVED BY (FOR MEMBER SERVICES SECTION)
SIGNATURE OVER PRINTED NAME _____ DATE _____ TIME _____

RECEIVED BY (FOR MEDICAL EVALUATION SECTION)
SIGNATURE OVER PRINTED NAME _____ DATE _____ TIME _____

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Republic of the Philippines
SOCIAL SECURITY SYSTEM

SICKNESS NOTIFICATION ACKNOWLEDGEMENT STUB

SS NUMBER/CRN (IF ANY) | NAME OF MEMBER (LAST NAME) (FIRSTNAME) (MIDDLE NAME) (SUFFIX)

RECEIVED BY

SIGNATURE OVER PRINTED NAME _____ POSITION TITLE _____ DATE & TIME _____ SSS BRANCH _____

THIS PORTION TO BE FILLED OUT BY SSS PERSONNEL

PART V - SCREENING RESULTS

MEMBER SERVICES SECTION

Screening was done and results are as follows:

- ☐ In order
- ☐ No signature of Employee
- ☐ No signature of Employer
- ☐ Medical Certificate not accomplished

Remarks:

SCREENED BY

SIGNATURE OVER PRINTED NAME _____ DATE _____ TIME _____

MEDICAL EVALUATION SECTION

Screening was done and results are as follows:

- ☐ In order
- ☐ With findings, please see remarks

Remarks:

SCREENED BY

SIGNATURE OVER PRINTED NAME _____ DATE _____ TIME _____

RECEIPT AND SCREENING (RE-FILED CLAIM)

- ☐ Claim accepted
- ☐ Claim not accepted (see remarks)

REMARKS _____

RECEIVED AND SCREENED BY

SIGNATURE OVER PRINTED NAME _____ DATE _____ TIME _____ DATE RETURNED _____

PART VI - MEDICAL EVALUATION

A. PHYSICAL EXAMINATION AND INTERVIEW

PERTINENT PE FINDINGS (Member to affix signature after PEI)

Onset of Illness _____

Last Working Day _____

Back to Work _____

Member's Signature _____

B. RECOMMENDATION

SS

APPROVED # of days

☐ Initial ☐ Extension (indicate previous approval)

(In numeric) _____ (In words) _____

(Inclusive Period) _____

☐ Previous approval _____

☐ Hospital (Confined) _____

(Date of Discharge)

☐ PENDING - ◯ For MFS ◯ HCD/ODS referral

Initials _____ Date _____

☐ RETURNED - _____

Initials _____ Date _____

☐ DENIED - _____

REMARKS

EC

APPROVED # of days

☐ Initial ☐ Extension (indicate previous approval)

(In numeric) _____ (In words) _____

(Inclusive Period) _____

☐ Previous approval _____

☐ Hospital (Confined) _____

(Date of Discharge)

☐ PENDING - ◯ For MFS ◯ HCD/ODS referral

Initials _____ Date _____

☐ RETURNED - _____

Initials _____ Date _____

☐ DENIED - _____

REMARKS

ILLNESS CODE/S

EVALUATED BY

SIGNATURE OVER PRINTED NAME _____ DATE _____

ENCODED AND RELEASED BY

SIGNATURE OVER PRINTED NAME _____ DATE _____

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) Please attach this notification to the Sickness Benefit Reimbursement Application.
4) Affix your initials on all alterations/erasures in this form.
5) Write SS Number and name of member in all the supporting documents submitted.
6) If member cannot sign, witnesses to fingerprinting shall be as follows:
   - Two (2) witnesses: One (1) witness is the employer/authorized representative 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.

ATTACHMENT/SUPPORTING DOCUMENTS

For prolonged confinements/sickness

- Laboratory, X-ray, ECG and other diagnostics results
- Operating room/clinical record that will support diagnosis

For sickness that occurred while on strike/shutdown

- Certificate of Notice of Strike issued by DOLE
- Certificate of Foreclosure
- Certificate of Non-advancement of Payment from Employer

For vehicular accident w/ 3rd party involvement (EC claim)

- Police Report

ON FILING OF NOTIFICATION

For Employed Members

- To avoid penalties for late filing, Sickness Notification (SN) form must be submited to employer within five (5) calendar days after start of confinement, except:
  - a) if confinement is in a hospital - deadline for notification is one (1) year from date of discharge
  - b) if sickness/injury occurred while at work or within company premises - Employer is deemed notified.
- For EC cases, sickness/injury must be recorded in the company logbook within five (5) calendar days from notice or knowledge of occurrence of the contingency. Failure to do so will mean employer liability to fifty (50) percent of the lump sum equivalent of the income benefit the employee is entitled.

For Employers

- To avoid penalties for late filing, employer may:
  - a) File the SN form at SSS within five (5) calendar days after its receipt from employee, including cases where sickness/injury occurred while at work or within company premises, or
  - b) Notify the system through the web and submit the SN form within thirty (30) calendar days after date of web notification.

REMINDER

Verification of status may be made thru the SSS Website at *www.sss.gov.ph* or contact our Call Center at 920-6446 to 55 or 917-7777.