PHILIPPINE PUBLIC SCHOOL TEACHERS ASSOCIATION, INC.
"Bayani ka, gurong Pilipino. Ang PPSTA, Kumakalinga sa iyo!"
PPSTA Bldg No.2, 245 Banawe Street, Quezon City
Claims Department
Website: www.ppsta.net Email Addresses: ppstaclaims@yahoo.com and support@ppsta.net
Tel. No. (02) 8988-1415 loc. 119,121,137 -138 & 142-143

APPLICATION FORM
HOSPITALIZATION DAILY INCOME BENEFIT

DATE: _____

Sir / Madam:

I have the honor to submit herewith a claim application for **Hospitalization daily income** under Mutual Retirement Benefit System Plus **(MRBS Plus).** The following information is hereby furnished.

_____	_____	_____
Printed name of member	**Signature**	**Division No.- Station No.–Employee No.**
_____	_____	_____
Date of Birth of Member	**Mobile Number**	**E-mail Address**

_____
Mailing Address

REQUIREMENTS FOR HOSPITALIZATION INCOME BENEFIT (to be attached to this application form)
1. Photocopy of two valid IDs reflecting clear signature
2. Original Medical certificate OR Medical abstract (admission date and discharge date must be indicated)
3. Original or Certified True Copy of Hospitalization Billing

Reminder:
* This application must be originally signed by the applicant.
* The signature in this application must be similar with the applicant's signature in the valid IDs that he/she will submit.
* Strictly No Erasure and Tampering.

Please send my PPSTA hospitalization daily income proceeds thru:

☐ **BDO Bank Remittance** ***(Note: Reference Number will be sent at stated Mobile No.*** ☐☐☐☐--☐☐☐--☐☐☐☐

☐ **Direct Deposit to Personal Account** ***(Note: Commercial Banks Only)***

To ensure that we are crediting the correct bank account, kindly provide the accurate bank account and personal details listed below for us to deposit your check.

1. **Account Name**: _____
2. **Name of Bank**:_____
3. **Bank Account Number**: _____ **Account Type**: ☐ **Current** ☐**Savings** ☐**Others**
4. **Bank Address/Branch**:_____
5. Any of the following scanned or photographed copy of your record or evidence of bank account **CLEARLY** showing both **ACCOUNT NAME** and **ACCOUNT NUMBER**

   5a. Bank account Passbook
   5b. Validated deposit slip
   5c. Bank Statement of Account
   5d. Screenshot of online banking account details

In the event of the approval of my application for hospitalization income benefit, I hereby authorize PPSTA to credit the proceeds of the said benefit to my personal account I have indicated.

☐ **Regional Office** _____

☐ **Mailing Address** _____

Upon receipt of the proceeds of the said benefit, I shall release and forever discharge the Association, its assigns and successors-in-interest from any similar claims whatsoever arising from my membership with the Association.

_____
Signature over printed name of member