DATE OF ISSUE : _____

FOR : Benefits Review Committee (BRC)

FROM : _____
NAME OF THE REQUESTING PARTY

DATE AND TIME OF NOTIFICATION:		
	DATE	TIME
CDW		
SPO		
SEDP MBA OFFICE		

NOTICE OF DEATH/DISABILITY OF _____

ADDRESS OF THE DECEASED/DISABLED	CAUSE OF DEATH/DISABILITY	DATE OF DEATH/DISABILITY

RELATION TO MEMBER	BIRTHDATE OF THE DECEASED/DISABLED	AGE	CIVIL STATUS OF THE DECEASED/DISABLED

NAME OF MEMBER	DATE OF MEMBERSHIP/MEMBERSHIP ID	SPO	CENTER

Attached are the Certified True Copy of the following documents:

(__) Marriage Contract – if the deceased/disabled person is the spouse and legitimate child of the member.
(__) Birth Certificate – if the deceased/disabled person is the member or his/her legal dependents.
(__) Death Certificate / (___) Doctor's Certificate of Total and Permanent Disability

Hope you will give an immediate attention to pay our benefits.

_____ DATE: _____
SIGNATURE OF THE REQUESTING PARTY

FOR : _____
NAME OF SPO MANAGER

SUBJECT : BRC RECOMMENDATION

Based on the submitted documents and on the investigation conducted regarding the death/disability of _____, it has been decided that SEDP MBA.

(___) must pay the benefit amounting to Php _____.
(___) must not to pay the benefit due to _____
(___) must hold the release of benefit in abeyance due to _____

To prove and validate the decision mentioned above, we the composition of the Benefits Review Committee (BRC) will sign this _____th day of _____, 20____.

NAME	SIGNATURE	NAME	SIGNATURE	NAME	SIGNATURE
_____ CENTER SECRETARY	_____	_____ CENTER TREASURER	_____	_____ SOCIAL SERVICE COOR.	_____
_____ CENTER AUDITOR	_____	_____ CENTER CHIEF	_____		

ATTESTED BY:

_____
SIGNATURE OF CDW OVER PRINTED NAME

SWORN STATEMENT OF THE BENEFICIARY

I, _____ hereby declare that the information I have given about the death/disability of _____ are true and correct to the best of my personal knowledge and that I attest to the authenticity of the documents submitted as required by the SEDP MBA. I therefore authorize the SEDP MBA to conduct its own investigation about the incident and to examine the documents submitted, and that should any information herein given found to be false, or the documents submitted be discovered to have been forged, I undertake to return the whole amount of benefits I received. In consideration of the foregoing, I shall submit myself for investigation, if necessary.

_____
SIGNATURE OF THE REQUESTING PARTY

DATE :_____

FOR : _____
NAME OF MBA MANAGER

SUBJECT : Burial Benefit/Disability Benefit

Based on the decision of Benefits Review Committee and after my investigation for the death/disability of_____, therefore:

(__) must pay the benefit amounting to Php _____
(__) not to pay the benefit due to _____
(__) pending the release of benefit due to _____

APPROVED BY: **ELLA S. GONZALO**

DATE: _____