



# MEMBER'S DATA FORM (MDF)

HQP-PFF-039  
(V09, 06/2022)

FOR Pag-IBIG Fund USE ONLY	
Pag-IBIG MID NUMBER	121317149783
REGISTRATION TRACKING NUMBER	923076241559

OCCUPATIONAL STATUS		UNEMPLOYED/NOT YET EMPLOYED			
MEMBERSHIP CATEGORY					
PERSONAL DETAILS					
NAME	LAST NAME	FIRST NAME	NAME EXTENSION	MIDDLE NAME	NO MIDDLE NAME
MEMBER	VILLARIAS	CARLO		TALARA	<input type="checkbox"/>
FATHER	VILLARIAS	JOLO		ROSOS	<input type="checkbox"/>
MOTHER (Maiden Name)	TALARA	MONINA		DEIPARINE	<input type="checkbox"/>
SPOUSE (if Married)					<input type="checkbox"/>
MEMBER'S NAME AS APPEARING IN THE BIRTH CERTIFICATE	VILLARIAS	CARLO		TALARA	<input type="checkbox"/>
DATE OF BIRTH		MARITAL STATUS		TAXPAYER IDENTIFICATION NUMBER (TIN)	
09/30/1994		Single/Unmarried			
PLACE OF BIRTH			CITIZENSHIP		SSS NUMBER
CEBU CITY, CEBU			FILIPINO		GSIS NUMBER
SEX	HEIGHT(cm.)	WEIGHT(kg.)	PROMINENT DISTINGUISHING FACIAL FEATURES		
MALE	0 00	0.00			
COMMON REFERENCE NUMBER (CRN)			FREQUENCY OF MEMBERSHIP SAVINGS (MS) PAYMENT		EMPLOYEE NUMBER
					For AFP/PNP Employee, Serial/Badge No.
					For DepEd Employee, Division Code-Station Code

ADDRESS AND CONTACT DETAILS					
PERMANENT HOME ADDRESS				COUNTRY + AREA CODE + TELEPHONE NUMBER	
Unit/Room No. Floor		Building Name		Home	
Lot No.	Block No.	Phase No.	House No	Street Name	Cell Phone
					+63 (0995) 3676802
Subdivision		Barangay		Business (Direct Line)	
		LAWAAN 2			
Municipality/City		Province/State/Country		Business (Trunk Line)	
TALISAY CITY		CEBU, PHILIPPINES			
ZIP Code				Email Address	
6045				carlo talara villanas@gmail.com	
PRESENT HOME ADDRESS					
Unit/Room No. Floor		Building Name		Phase No.	
House No		Street Name		Subdivision	
				Barangay	
				LAWAAN 2	
Municipality/City		Province/State/Country		ZIP Code	
TALISAY CITY		CEBU, PHILIPPINES		6045	
PREFERRED MAILING ADDRESS		PRESENT HOME ADDRESS			

THIS FORM MAY BE REPRODUCED. NOT FOR SALE.

**PHILIPPINE HEALTH INSURANCE CORPORATION**

8/F, Golden Peak Tower, Gorordo Ave., cor. Escario St., Cebu City 6000

(032) 233 7407 (032) 233 7523 (032) 233 3287 (fax) (032) 233 3281 (032) 233 7871

[www.philhealth.gov.ph](http://www.philhealth.gov.ph)**MEMBER DATA RECORD****MEMBER BASIC INFORMATION**

PhilHealth Identification Number (PIN) : **122519688288** PhilSys Number :  
 Member Category : DIRECT CONTRIBUTOR - SELF  
 EARNING INDIVIDUAL - INDIVIDUAL NHTS Coverage : N/A  
 Validity Period : N/A

**VILLARIAS, CARLO TALARA**

LAWAAN II, TALISAY, CEBU - 6045

Foreign Address : N/A Sex : MALE  
 Date of Birth : 9/30/1994  
 Place of Birth : CEBU CITY, CEBU  
 Contact No. (Foreign) : N/A Civil Status : SINGLE  
 (Local) : /09953676802 Tax Identification Number :

**ENTITY INFORMATION**

Philhealth Number (PEN/POGN) : N/A  
 Name of Employer/Organized Group : N/A  
 Business Address : N/A  
 Telephone Number : N/A Employment Status: N/A  
 Tax Identification Number : N/A Date : N/A

**DEPENDENT INFORMATION**

PIN	Surname	Given Name	Middle Name	Sex	Relation	Date of Birth
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\*\*\* NO DECLARED DEPENDENT/S \*\*\*

**MARJORIE A. CABRIETO**  
 REGIONAL VICE PRESIDENT  
 PRO - VII Cebu City

**Paalala :** Basahin ang nilalaman ng MDR. Kung may kulang o mali, ibalik agad upang maidagdag o maiwasto. Ingatan ang orihinal na kopya at huwag ibigay kahit kanino. Kung sakaling gagamit at makikinabang ng benepisyo, magbigay ng kopya sa ospital. *Read the contents of the MDR. Should there be any data discrepancies, return it back to amend or rectify the error. Take good care of the MDR and do not hand it over to anybody. Provide photocopy to hospital in case of confinement and availment of benefits.)*



COV-01205 (05-2015)

# Republic of the Philippines SOCIAL SECURITY SYSTEM REQUEST/VERIFICATION FORM

**THIS FORM MAY BE REPRODUCED AND IS NOT FOR SALE**

PLEASE READ THE INSTRUCTIONS AND REMINDERS AT THE BACK BEFORE FILLING OUT THIS FORM. PRINT ALL INFORMATION IN CAPITAL LETTERS AND USE BLACK OR BLUE INK ONLY.

### PART I - TO BE FILLED OUT BY MEMBER

#### A. MEMBER INFORMATION

SS NUMBER	COMMON REFERENCE NUMBER	DATE OF BIRTH (MMDDYYYY) 09/30/1994	TAX IDENTIFICATION NUMBER (IF ANY)
NAME (LAST NAME) <b>VILLARIAS</b>	(FIRST NAME) <b>CARLO</b>	(MIDDLE NAME) <b>TALARA</b>	(SUFFIX)
LOCAL ADDRESS (SUBDIVISION) <b>LAWAAN 2</b>	(RM./FLR./UNIT NO. & BLDG. NAME)	(HOUSE/LOT & BLK. NO.)	(STREET NAME)
(CITY/MUNICIPALITY) <b>TALISAY</b>	(PROVINCE) <b>CEBU</b>	ZIP CODE <b>610415</b>	
TELEPHONE NUMBER (AREA CODE + TEL. NO.)	MOBILE/CELLPHONE NUMBER 09953676802	E-MAIL ADDRESS carlo.talara.villarias@g.c.	GENDER <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE
FOREIGN ADDRESS (IF APPLICABLE)	COUNTRY	ZIP CODE	
TYPE OF MEMBERSHIP <input type="checkbox"/> EMPLOYED <input checked="" type="checkbox"/> VOLUNTARY <input type="checkbox"/> SELF-EMPLOYED <input type="checkbox"/> NON-WORKING SPOUSE <input type="checkbox"/> OVERSEAS FILIPINO WORKER			

#### B. TYPE OF TRANSACTION

REQUEST

Cancellation of Multiple SS Numbers, indicate the following information:  
 Civil Status \_\_\_\_\_  
 Maiden Name (if female) \_\_\_\_\_  
 Name of Father \_\_\_\_\_  
 Name of Mother \_\_\_\_\_  
 Name of Spouse \_\_\_\_\_  
 Name of Child/Children 1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_

Consolidation of Contributions (for members with multiple employers)  
 Correction/Refund/Posting/Adjustment of Contributions  
 Deletion of Entry in Employment History Record  
 Encoding/Correction of Date of Coverage  
 Manual Verification

Employment History (To be filled-out by member requesting for the above request/s) - Please use separate sheet if necessary

	NAME OF EMPLOYER	ADDRESS	PERIOD OF EMPLOYMENT	
			FROM (MMYYYY)	TO (MMYYYY)
1				
2				

Certification of Membership/Non-Membership  
 Copy of Membership Record/s \_\_\_\_\_ (Record Type)  
 Print-out of Computer Records (EE Static Information/Actual Premiums/Flexi-Fund Premiums/SSS P.E.S.O. Fund Premiums/Employment History/Claims Information)  
 Others \_\_\_\_\_

VERIFICATION

Contribution (Indicate Period Covered) \_\_\_\_\_  
 Date of Coverage \_\_\_\_\_  
 Employer Number \_\_\_\_\_  
 SS Number \_\_\_\_\_  
 Flexi-Fund Premiums \_\_\_\_\_  
 SSS P.E.S.O. Fund Premiums \_\_\_\_\_  
 Loan Balance \_\_\_\_\_  
 Loans/Benefits Eligibility \_\_\_\_\_  
 Status of:  
 Loan Application \_\_\_\_\_  
 Benefits Claim Application (sickness/maternity/EC/disability/retirement/death/funeral) \_\_\_\_\_  
 Application for UMID Card \_\_\_\_\_  
 Data Change Requested \_\_\_\_\_  
 Others \_\_\_\_\_

#### C. CERTIFICATION

I certify that the information provided in this form are true and correct.

**CARLO T. VILLARIAS**

PRINTED NAME

SIGNATURE

**3/20/2023**

DATE

#### D. AUTHORIZATION (To be filled out by member with authorized representative or company representative only)

I authorize Mr./Ms. \_\_\_\_\_ to request/verify the information requested above and/or sign documents necessary for the release of the result of the said request/verification

PRINTED NAME & SIGNATURE OF MEMBER

DATE

PRINTED NAME & SIGNATURE OF AUTHORIZED REP.

DATE

#### PART I - TO BE FILLED OUT BY SSS

Preference for release of request/verification  
 For Mailing  For Pick-up (indicate date & time) \_\_\_\_\_

Identification document/s presented by herein named authorized/co. representative:  
 SS  Two (2) valid IDs \_\_\_\_\_



### Republic of the Philippines SOCIAL SECURITY SYSTEM REQUEST/VERIFICATION FORM ACKNOWLEDGEMENT STUB

SS NUMBER/COMMON REFERENCE NUMBER (IF ANY) NAME (LAST NAME) (FIRST NAME) (MIDDLE NAME) (SUFFIX)

RECEIVED BY \_\_\_\_\_ POSITION TITLE \_\_\_\_\_ DATE & TIME \_\_\_\_\_ BRANCH \_\_\_\_\_

SIGNATURE OVER PRINTED NAME \_\_\_\_\_

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

**A. TRANSACTION RESULTS**

**REQUEST**

- |  |   |
|--|---|
| <input type="checkbox"/> Cancellation of Multiple SS Numbers                   | <input type="checkbox"/> Deletion of Entry in Employment History Record |
| <input type="checkbox"/> Consolidation of Contributions                        | <input type="checkbox"/> Encoding/Correction of Date of Coverage        |
| <input type="checkbox"/> Correction/Refund/Posting/Adjustment of Contributions | <input type="checkbox"/> Manual Verification                            |
| <input type="checkbox"/> Certification of Membership/Non-Membership            | <input type="checkbox"/> Print-out of Computer Records                  |
| <input type="checkbox"/> Copy of Membership Record/s                           | <input type="checkbox"/> Others   |

**VERIFICATION**

- |  |   |
|--|---|
| <input type="checkbox"/> Contribution                            | <input type="checkbox"/> Loan Balance               |
| <input type="checkbox"/> Date of Coverage                        | <input type="checkbox"/> Loans/Benefits Eligibility |
| <input type="checkbox"/> Employer Number                         | <input type="checkbox"/> Status of:                 |
| <input checked="" type="checkbox"/> SS Number <u>06.46947545</u> | <input type="checkbox"/> Loan Application           |
| <input type="checkbox"/> Flexi-Fund Premiums                     | <input type="checkbox"/> Benefits Claim Application |
| <input type="checkbox"/> SSS P.E.S.O Fund Premiums               | <input type="checkbox"/> Application for UMID Card  |
|  | <input type="checkbox"/> Data Change Requested      |
|  | <input type="checkbox"/> Others                     |

**B. TO BE FILLED OUT BY DEPARTMENT/BRANCH CONCERNED**

VERIFIED/PROCESSED BY			RELEASED BY		
SIGNATURE OVER PRINTED NAME	DEPT./BRANCH	DATE & TIME	SIGNATURE OVER PRINTED NAME	DEPT./BRANCH	DATE & TIME

**INSTRUCTIONS**

1. Fill out this form in one (1) copy and accomplish appropriate parts as follows.
  - Filed by member
    - Member to fill-out PART I (a to c)
    - Member to fill-out "Employment History" (Part I [b]) only if requesting for the following:
      - Cancellation of Multiple SS Number
      - Consolidation of Contributions
      - Correction/Refund/Posting/Adjustment of Contributions
      - Deletion of Entry in Employment History Record
      - Encoding/Correction of Date of Coverage
      - Manual Verification
  - Filed by authorized representative or company representative
    - Member to fill-out PART I (a to d)
    - Authorized Representative or company representative to fill out PART I (d)
2. Place a checkmark on the applicable box.
3. Always indicate "N/A" or "Not Applicable", if the required data is not applicable.
4. Present identification document/s.
  - Filed by member
    - Social Security (SS) Card or Unified Multi-Purpose ID (UMID) Card or Passport or Professional Regulation Commission (PRC) Card or Seaman's Book or Driver's License or two (2) valid IDs (both with signature and at least one (1) with photo)
  - Filed by authorized representative
    - Representative's SS Card or UMID Card or Passport or PRC Card or Seaman's Book or Driver's License or any two (2) valid IDs (both with signature and at least one (1) with photo)
    - Member's SS Card or UMID Card or Passport or PRC Card or Seaman's Book or Driver's License or any two (2) valid IDs (both with signature and at least one (1) with photo)
  - Filed by company representative
    - Authorized Representative Card (ACR)
    - Original member's SS Card or UMID Card or Passport or PRC Card or Seaman's Book or Driver's License or any two (2) valid IDs (both with signature and at least one (1) with photo)
5. The member granting authority to the authorized representative or company representative in this form shall be held liable under all circumstances for any false statement, misrepresentation, fraud made by the authorized representative or company representative in all transactions with the SSS.
6. This form can be downloaded thru the SSS Website at [www.sss.gov.ph](http://www.sss.gov.ph).