



E-4

COV-01215 (08-2015)

Republic of the Philippines SOCIAL SECURITY SYSTEM MEMBER DATA CHANGE REQUEST

THIS FORM MAY BE REPRODUCED AND IS NOT FOR SALE. THIS CAN ALSO BE DOWNLOADED FROM 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 AND USE BLACK INK ONLY.

PART I - TO BE FILLED OUT BY MEMBER

A. PERSONAL DATA

SS NUMBER 315131121903	COMMON REFERENCE NUMBER (if any)	DATE OF BIRTH (mm/dd/yyyy) 11/08/2001	TAX IDENTIFICATION NUMBER (if any)
NAME (LAST NAME) OLIVAN	(FIRST NAME) LEA JANE	(MIDDLE NAME) DORIA	(SUFFIX)
ADDRESS (HOUSE/UNIT NO. & BLDG. NAME)		(REGUR/LOT & BLK NO.)	(CITY/TOWN)
(SUBDIVISION)	(BARANGAY/DISTRICT/LOCALITY) POBACION 1	(CITY/MUNICIPALITY) GENERAL LUNA	(PROVINCE) SURIGAO DEL NORTE
TELEPHONE NUMBER (AREA CODE + TEL. NO.)	MOBILE/CELLPHONE NUMBER	E-MAIL ADDRESS	
FOREIGN ADDRESS (if applicable)		COUNTRY	ZIP CODE

B. DATA CHANGE/CORRECTION/UPDATING

CHANGE OF MEMBERSHIP TYPE

<p>FROM</p> <input type="checkbox"/> Employed <input type="checkbox"/> Voluntary <input type="checkbox"/> Overseas Filipino Worker <input type="checkbox"/> Non-Working Spouse (NWS) <input type="checkbox"/> Prior Registrant <small>(A person who registered with the SSS for the first time as a prospective employee.)</small>	<p>TO</p> <input type="checkbox"/> Self-Employed (Please fill-out the details below.) Professor/Business <u>N/A</u> Year Professor/Business Started _____ Monthly Earnings (P) _____	<p>TO (Option for Prior Registrant Only)</p> <input type="checkbox"/> Non-Working Spouse (Please fill-out the details below.) SS No./CRN of Working Spouse _____ Monthly Income of Working Spouse (P) _____ I AGREE WITH MY SPOUSE'S MEMBERSHIP WITH SSS. SIGNATURE OVER PRINTED NAME OF WORKING SPOUSE _____
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CORRECTION OF NAME

<input type="checkbox"/> Last Name	FROM	TO
<input type="checkbox"/> First Name	<u>N/A</u>	
<input type="checkbox"/> Middle Name <small>(or change of middle initial to middle name)</small>	<u>N/A</u>	
<input type="checkbox"/> Prefix (e.g., "de", "del", "delos", "del", "Ma." or "Marie") or Suffix (e.g., Jr., II or III)	<u>N/A</u>	
<input type="checkbox"/> Simple Error in Spelling of Name (e.g., "r" to "e" or "v" to "o" or vice versa; inclusion/deletion of space and special characters)	<u>N/A</u>	
<input type="checkbox"/> Due to to Re-merriage	<u>N/A</u>	

CORRECTION OF DATE OF BIRTH

CORRECTION OF SEX

CHANGE OF CIVIL STATUS
(For Female members: Accomplish the FROM and TO portions. If also requesting for change of name)

<input type="checkbox"/> Single to Married	FROM	TO
<input type="checkbox"/> Married to Legally Separated	<u>N/A</u>	
<input type="checkbox"/> Married to Widowed	<u>N/A</u>	
<input type="checkbox"/> Reversion from Married to Single	<u>N/A</u>	

UPDATING OF CONTACT INFORMATION

Address Telephone Number E-mail Address Mobile/Cellphone Number

UPDATING OF BANK INFORMATION

Bank Name	Bank Branch	Account Number
_____	_____	_____

Benefits (Sickness/ Maternity/Partial Disability)

Loans

PESO Fund

UPDATING OF MEMBER RECORD STATUS (From "Temporary" to "Permanent") - please indicate submitted documents

BIRTH CERTIFICATE

UPDATING OF DEPENDENT(S)/BENEFICIARY(IES) (Please check the appropriate box. If more than 3, use other page "Instructions" portion.)

NAME (LAST NAME)	(FIRST NAME)	(MIDDLE NAME)	(SUFFIX)	RELATIONSHIP TO MEMBER	DATE OF BIRTH (mm/dd/yyyy)	<input type="checkbox"/> New/Additional	<input type="checkbox"/> Deletion
1.				<u>N/A</u>			
2.							
3.							

CERTIFICATION

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

SS NUMBER
315131318131617

OCT 16 2024

LEX JANE DORIA OLIVAN
PRINTED NAME

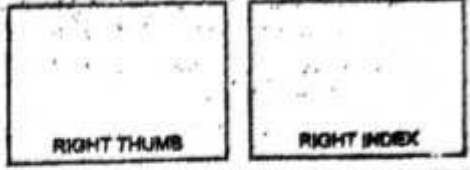
[Signature]
SIGNATURE

DATE

If member cannot sign, affix fingerprints (please see instruction no. 5).
Below are the witnesses to fingerprinting:

1) PRINTED NAME SIGNATURE DATE
ADDRESS & CONTACT NUMBER

2) PRINTED NAME SIGNATURE DATE
ADDRESS & CONTACT NUMBER



PART II - TO BE FILLED OUT BY SSS

For Change of Membership Type to Self-Employed
Business Code _____
Approved MSC _____
Start of Payment _____
Monthly SS Contribution (P) _____

For Change of Membership Type to Non-Working Spouse
Working Spouse's MSC _____
Approved MSC of NWS _____
Start of Payment _____
Monthly SS Contribution (P) _____

RECEIVED BY *[Signature]*
SIGNATURE OVER PRINTED NAME
DATE & TIME
OCT 16 2024

ENCODED BY *[Signature]*
SIGNATURE OVER PRINTED NAME
DATE & TIME
OCT 16 2024

INSTRUCTIONS

- Fill out this form in two (2) copies and submit to the nearest SSS branch office together with the required documents. Refer to the attached "List of Documentary Requirements for Member Data Change Request".
- Always indicate "N/A" or "Not Applicable", if the required data is not applicable.
- Present original copy and submit photocopy/ies of the following identification (ID) card/s in filing this form:
 - Filed by member
 - Social Security (SS) card or Unified Multi-Purpose ID (UMID) card or two (2) ID cards both with signature and one (1) with photo
 - Filed by employer or company representative or household employer
 - SS card or UMID card or two (2) ID cards of the member, both with signature and one (1) with photo; and
 - Additional ID card/s per type of filer
 - Company ID of the employer-filer, with signature and photo, if filed by employer
 - Specimen Signature Card (SS Form L-501) of the company representative, if filed by company representative
 - Two (2) ID cards of the household employer-filer, both with signature and one (1) with photo, if filed by household employer
- If member is requesting for updating of contact information (address, telephone number, e-mail address and mobile/cellphone number), indicate already under Part I-A of the form the new contact information.
- If member cannot sign, witnesses to fingerprinting shall be as follows:
 - Filed by member
 - SSS receiving personnel who shall affix his/her signature on the portion provided for in Part I-C.
 - Filed by employer or company representative or household employer
 - Two (2) witnesses. Both should affix their signatures and indicate their addresses and contact numbers on the portions provided for in Part I-C. One (1) witness is the member's employer or company representative or household employer himself and the other one (1) could be any person.
- If dependents/beneficiaries are more than three (3), please use space provided below.

UPDATING OF DEPENDENT(S)/BENEFICIARY(IES) (Please check the appropriate box.)

NAME (LAST NAME)	FIRST NAME	MIDDLE NAME	(SUFFIX)	RELATIONSHIP TO MEMBER	DATE OF BIRTH (mm/yyyy)	
						<input type="checkbox"/> New/Additional <input type="checkbox"/> Deletion
						<input type="checkbox"/> New/Additional <input type="checkbox"/> Deletion
						<input type="checkbox"/> New/Additional <input type="checkbox"/> Deletion
						<input type="checkbox"/> New/Additional <input type="checkbox"/> Deletion
						<input type="checkbox"/> New/Additional <input type="checkbox"/> Deletion