



GOV-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: 01812911131031515
COMMON REFERENCE NUMBER:
DATE OF BIRTH (MMDDYYYY): 04/10/1996
TAX IDENTIFICATION NUMBER (IF ANY):
NAME (LAST, FIRST, MIDDLE, SUFFIX): DELA CERNA, WENNIE JOY, DELA CRUZ
LOCAL ADDRESS (SUBDIVISION, BARANGAY/DISTRICT/LOCALITY, CITY/MUNICIPALITY, PROVINCE, ZIP CODE): LUMBIA, CAGAYAN DE ORO, MISAMIS ORIENTAL, 9101010
TELEPHONE NUMBER (AREA CODE + TEL NO.), MOBILE/CELLPHONE NUMBER, E-MAIL ADDRESS (delacernawenniejoy@gmail.com), GENDER (MALE, FEMALE)
FOREIGN ADDRESS (IF APPLICABLE), COUNTRY, ZIP CODE
TYPE OF MEMBERSHIP (EMPLOYED, VOLUNTARY, SELF-EMPLOYED, NON-WORKING SPOUSE, OVERSEAS FILIPINO WORKER)

B. TYPE OF TRANSACTION

REQUEST

- Cancellation of Multiple SS Numbers, indicate the following information: Civil Status (SINGLE), 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

Table with columns: NAME OF EMPLOYER, ADDRESS, PERIOD OF EMPLOYMENT (FROM, TO). Entry 1: SM SUPERVALUE INC., CAGAYAN DE ORO CITY, 03/20/11 to 06/20/19.

- 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.

Signature: WENNIE JOY D. DELA CERNA, DATE: 04-08-2022

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

Perforate Here



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ACKNOWLEDGEMENT STUB

SS NUMBER/Common Reference Number (if any), NAME (LAST, FIRST, MIDDLE, SUFFIX)

RECEIVED BY, SIGNATURE OVER PRINTED NAME, POSITION TITLE, DATE & TIME, BRANCH