OVERSEAS WORKERS WELFARE ADMINISTRATION
INSURANCE BENEFIT
(DISABILITY CLAIM)

ID PICTURE OF OFW

Regional Welfare Office _____ Application No. _____

APPLICANT'S DATA ☐ Land-based ☐ Sea-based

Name of OFW: _____
(LAST) (FIRST) (MIDDLE)

Sex: ____ Civil Status: _____ Birthdate: _____ Birthplace: _____ Age: ____

Permanent Address: _____

_____ Tel/CP No.: _____

Agency: _____ Employer: _____

Jobsite: _____ Position: _____

Contract Processed: _____ Duration: _____

_____ _____
SIGNATURE Date

DOCUMENTS SUBMITTED:

( ) Medical Cert. /Medical Exam procedure result ( ) Passport/Seaman's Service Record Book
( ) Accident/Master's Report ( ) Others

RECEIVED BY: _____ Date: _____

MEDICAL EVALUATION

Nature of Disability/Final Diagnosis: Compensation Level: _____

_____
Medical Evaluator
License No.: _____

VERIFICATION

☐ With previous availment ☐ Without previous availment

By: _____ Date: _____

EVALUATION

By: _____

Date: _____

RECOMMENDATION: **APPROVED:**

Applicant is entitled to P_____

_____ _____
CHIEF, PSD **RWO DIRECTOR**

_____ _____
Date Date