HCSCCO Form No. MEM-010
REVISED SEPTEMBER 2020

HOLY CROSS SAVINGS & CREDIT COOPERATIVE

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HOSPITAL INCOME BENEFIT (HIB) APPLICATION FORM

☐ **HEAD OFFICE** ☐ **BRANCH:** ________________
Return Date:________________

MEMBER'S/CLAIMANT'S INFORMATION			
NAME OF MEMBER: (Surname) (Given Name) (Middle Name) (Suffix)		CLIENT ID NO.:	CONTACT NO.:
PRESENT ADDRESS:			E-MAIL ADDRESS:
DATE OF BIRTH:	GENDER: ☐ Female ☐ Male	CIVIL STATUS: ☐ Single ☐ Married ☐ Widow/Widower ☐ Legally Separated	
DATE OF HOSPITALIZATION: From (mm-dd-yyyy) To (mm-dd-yyyy)		NAME OF HOSPITAL:	

CERTIFICATION

I / We hereby certify that the information provided hereon is true and correct.

________________________ Member's Signature over Printed Name
________________________ Representative's Signature over Printed Name
________________ Date Signed

(FOR HCSCCO USE ONLY)

No. of Days Member's Confinement: ____________ **HIB Amount: P** ________________ ____________

I. Submitted Documents: (HO/BRANCH)	DATE/TIME	REMARKS	INITIALS
Received by:			
Checked by:			
II. Transmittal (HO)			
Received by:			
Checked/Verified By:			
III. Recommended By:			
1. Branch Operations Manager			
2. Membership & Marketing Manager			
3. Credit & Collections Manager			
4. Accounting, Compliance & Finance Manager			
IV. Approved for Release:			
Chief Executive Officer			

CHECK PAYABLE TO: ____

***Note: Five (5) working days processing after all requirements are completely submitted.**

Requirements: Remarks

1. Original Copy or Original Certified True Copy (CTC) of Medical Certificate; _____________
2. Original Copy or Original CTC of Hospital Bill with Confinement & Discharge Date; _____________
3. Original Copy or Original CTC of Medical Abstract or Discharge Summary; _____________
4. Photocopy of Official Receipt (if any); _____________
5. Photocopy of Two (2) Valid IDs of Member & Authorized Claimant; _____________
6. Original Authorization Letter to file, receive and encash claim benefit given to spouse or child(ren) if the member cannot file, receive and encash the claim benefit; _____________
7. Print-out of Member's Summary of Account & Mortuary Fund SL. _____________
8. Print-out of GRTL/CLSP/LPP from CLIMBS. _____________

OTHER REQUIREMENTS (as prescribed by (HCSCCO Officer): ________________________________

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REMARKS: ____

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