**NPC - PROVIDENT FUND** FORM No. 013 (HFAP)

# PF HEALTH & FINANCIAL ASSISTANCE PROGRAM (HFAP)

**Important:** Please read rules and regulations at the back before filing out this form.
Forms not completely filled out and lack of requirements shall not be accepted and processed.

| Application No. | Program | Amount |
|---|---|---|
| | ☐ Health Program<br>☐ Financial Assistance<br>☐ Calamity Program | P 5,000.00 |

**Payment Preference**

☐ Through Check ☐ Through Cash Card (Attach Cash Card copy) 60-3131 - 0230 - __ __ __ __ - __ __

## TO BE FILLED UP BY THE MEMBER / APPLICANT

| DCE No. | Last Name | First Name | Middle Name | Nature of Appointment | Contact No. (Cel#/Local) |
|---|---|---|---|---|---|
| | | | | | |

| Position | CC No. / Name | Date of Birth (mmddyy) | Region |
|---|---|---|---|
| | | | ☐ HO ☐ Spug Luzon ☐ Spug Visayas ☐ Spug Mindanao ☐ Plants ______________ |

## COMPONENTS

☐ **A. HEALTH RELATED**

| | |
|---|---|
| ☐ Cardiovascular Disease | ☐ Different Kinds of Cancer / Tumor of Internal Organs |
| ☐ Essential Hypertension | ☐ Cirrhosis of the Liver / Chronic Liver Disease |
| ☐ Coronary Artery Disease | ☐ Diabetes Mellitus and its complications (Neuropathy, Retinopathy, Neopathy etc) |
| ☐ Stroke/Aneurosym | ☐ Major Operation (Hysterectomy etc.) |
| ☐ Angioplasty | ☐ Asthma and Tuberculosis |
| ☐ Kidney / Renal Failure / Dialysis | ☐ Surgical Interventions (Heart, abdominal, brain etc) |

| Name and Address of Hospital | Period of Confinement |
|---|---|
| | |

☐ **B. OTHER CASES VALIDATED BY NPC HEALTH SERVICE GROUP** Case: ________________________________________

☐ **C. DEATH DUE TO DIFFERENT KINDS OF DISEASES AND/OR ACCIDENTS**

☐ **D. CALAMITY** Address: ______________________________________________________________________________

## SWORN STATEMENT

I also certify that; a) I am ( ) permanent employee of the Corporation; b) ( ) I am an active member of Provident Fund; c) ( ) I am not under preventive suspension involving withholding of salary; d) ( ) there is no pending administrative and/or criminal charge against me; e) ( ) all the information I have reported in this application are true and correct.

_______________________________
Signature Over Printed Name
Applicant

## CHECKLIST REQUIREMENT

| HEALTH ASSISTANCE | OTHER CASES | ETERNAL LIFE ASSISTANCE | CALAMITY PROGRAM |
|---|---|---|---|
| ☐ Company ID<br>☐ Statement of Account<br>☐ Doctor's Certificate | ☐ Company ID | ☐ Company ID<br>☐ Dealth Certificate (Certified True Copy)<br>☐ Birth Certificate / Marriage Contract of Beneficiary<br>☐ Valid ID of Beneficiary | ☐ Company ID<br>☐ Declared Calamity Area |

| COMBEN / HR REGIONAL COUNTERPART | TO BE ACCOMPLISHED BY NPC - PF LOAN ANALYST | | | |
|---|---|---|---|---|
| Verified by: | Processed by: | Audited by: | Reviewed by: | Approved by: |
| ____________________<br>COMBEN / HR Regional Counterpart | **J.S.BALLESTEROS**<br>**Loan Analyst** | **F.B. DAYAO**<br>**Financial Analyst** | **THELMA G. CABILA**<br>**Section Chief** | **R.M. MANANSALA**<br>**NPC - PF Administrator** |