



Healthcare Fund  
**SOCIAL SECURITY ADMINISTRATION**  
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# QUARTERLY NHI SUBSCRIPTION PAYMENT FORM

Payment for Quarter Ending: \_\_\_\_\_

Payer's Name (Print): \_\_\_\_\_ SSN: \_\_\_\_\_ Tel No. \_\_\_\_\_

Name of Person to Be Insured	Social Security Number	Cost per Quarter	Quarters of Coverage	Total Payment:
1.		\$40.95	x	= \$
2.		\$40.95	x	= \$
3.		\$40.95	x	= \$
4.		\$40.95	x	= \$

**Subtotal:** \$

**Deadlines for Quarterly NHI Subscription Payments:**

1st Quarter: April 30 | 2nd Quarter: July 31 | 3rd Quarter: October 31 | 4th Quarter: January 31

**Adjustment:** \$

**Total Amount Due:** \$

I understand and agree with the following:

- My payment for the NHI Subscription Cost is not refundable.
- If this is the first time I am paying an NHI subscription cost or if I have not been previously covered by NHI, I understand that coverage will not begin until the first day of the quarter after two consecutive quarters of payment of subscription costs.

Signature of Payer: \_\_\_\_\_ Date: \_\_\_\_\_

ROPSSA 900 - 25 (rev. 07/17)

FOR OFFICE USE ONLY				
DATE PAID:	AMOUNT PAID:	RECEIPT NO.:	RECEIVED BY:	VERIFIED BY: