REPUBLIC OF PALAU
HCF
HEALTHCARE FUND

Healthcare Fund
SOCIAL SECURITY ADMINISTRATION
P.O. Box 679 Koror, Palau 96940
Tel: 488-2457 | Fax: 488-1470
administration@ropssa.org
www.ropssa.org

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.		$58.50	x		=	$
2.		$58.50	x		=	$
3.		$58.50	x		=	$
4.		$58.50	x		=	$
				Subtotal:		$
				Adjustment:		$
				Total Amount Due:		$

Deadlines for Quarterly NHI Subscription Payments:
1st Quarter: April 30 | 2nd Quarter: July 31 | 3rd Quarter: October 31 | 4th Quarter: January 31

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 <u>after</u> two consecutive quarters of payment of subscription costs.*

Signature of Payer: _____ Date: _____

ROPSSA 900 – 25 (rev. 04/26)

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