Republic of the Philippines
DEPARTMENT OF EDUCATION
Region XI
SCHOOLS DIVISION OF DIGOS CITY
Digos City

Office of the City Schools Division Superintendent *Telefax No.: 0825538396; 0825538376*
Email address: depeddigos7@gmail.com

Division Memorandum No. 014, s. 2017

TO: PUBLIC SHOOLS DISTRICT SUPERVISORS
ALL SCHOOL HEADS (Elementary and Secondary Level)
DIVISION OFFICE PERSONNEL

FROM: For and in the absence of the Schools Division Superintendent:

EMMANUEL P. HUGO
Chief Education Supervisor
Schools Governance and Operations Division

SUBJECT: UPDATE OF MEMBERSHIP FOR PHILIPPINE HEALTH INSURANCE CORPORATION OF ALL DEPED – SCHOOLS DIVISION OF DIGOS EMPLOYEES.

DATE: January 9, 2017

To assist the Philippine Health Insurance Corporation (PhilHealth) on the proper posting of contributions, we are requesting all employees of DepEd – Schools Division of Digos City to update their membership by accomplishing the Philhealth Member Registration Form (PMRF). School heads are requested to prepare the Report of Employee – Members (Er2) after the accomplishment of PMRFs and submit the accomplished PMRFs and Er2 to the Accounting Section. Deadline for submission will be on or before January 16, 2017 to comply with the deadline given by PhilHealth.

Attached is the machine copy of the PMRF and Er2.

Please be guided accordingly.

DepEd Schools Division of Digos
RELEASED 258
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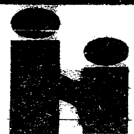
By:

PLEASE READ INSTRUCTIONS AT THE BACK BEFORE ACCOMPLISHING THIS FORM



PHILHEALTH

REPORT OF EMPLOYEE-MEMBERS

(CHECK APPLICABLE BOX) ☐ INITIAL LIST (Attach to PhilHealth Form Er1)
☐ SUBSEQUENT LIST

NAME OF EMPLOYER / FIRM: **PhilHealth Employer No.**

COMPLETE ADDRESS: **TELEPHONE:** **EMAIL ADDRESS:**

PHILHEALTH/ SSS/GSIS NUMBER	**NAME OF EMPLOYEE** (LAST NAME, FIRST NAME MIDDLE NAME)	**POSITION**	**SALARY**	**DATE OF EMPLOYMENT**	**(DO NOT FILL) EFF. DATE OF COVERAGE**	**PREVIOUS EMPLOYER (IF ANY)**

TOTAL NO. LISTED ABOVE: _____

PLS. ARRANGE NAMES OF EMPLOYEES IN ALPHABETICAL ORDER

PAGE ____OF___SHEETS

CERTIFIED CORRECT:

____

SIGNATURE OVER PRINTED NAME *OF HEAD OF AGENCY OR AUTHORIZED REPRESENTATIVE* **AND DESIGNATION**

Note: **THIS FORM CAN BE REPRODUCED BUT IS NOT FOR SALE *and* IS TO BE ACCOMPLISHED IN DUPLICATE.**

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre Building, 709 Shaw Boulevard, Pasig City
Healthline 441-7444 www.philhealth.gov.ph

PMRF

PHILHEALTH MEMBER REGISTRATION FORM
(October 2013)

PhilHealth Identification Number (PIN)

IMPORTANT REMINDERS:

1. Your PhilHealth Identification Number (PIN) is your unique and permanent number.
2. The issuance of the PIN does not automatically qualify you or your dependents to be entitled to NHIP benefits.
3. Always use your PIN in all transactions with PhilHealth.

Please carefully read instructions at the back before accomplishing this form.

PURPOSE: ☐ FOR ENROLLMENT ☐ FOR UPDATING

1. MEMBER INFORMATION

Last Name	First Name	Name Extension (JR/SR/III)	Middle Name

If Married Female, please write FULL MAIDEN NAME:

Last Name	First Name	Name Extension (JR/SR/III)	Middle Name

Date of Birth (mm-dd-yyyy)	Place of Birth (City/Municipality/Province)	Sex	Civil Status	Nationality	Tax Identification No.(TIN)
		☐ Male ☐ Female	☐ Single ☐ Widow(er) ☐ Married ☐ Legally Separated		

Permanent Address

Unit/Room No./Floor	Building Name	Lot/Block/House/Bldg. No.	Street	Subdivision/Village

Barangay	City/Municipality	Province	Country	Zip Code

Contact Information

Landline Number (Area Code + Tel. No.)	Mobile Number	E-mail Address

2. DECLARATION OF DEPENDENTS (Use separate sheet if necessary)

2.1 Legal Spouse

PhilHealth Identification Number (PIN)	Last Name	First Name	Name Extension (JR/SR/III)	Middle Name	Date of Birth mm-dd-yyyy	Sex M / F

2.2 Children below 21 years old (unmarried & unemployed) and/or Children 21 years old and above with permanent disability

PhilHealth Identification Number (PIN)	Last Name	First Name	Name Extension (JR/SR/III)	Middle Name	Mark √ if with Disability	Date of Birth mm-dd-yyyy	Sex M / F
					☐		
					☐		
					☐		

2.3 Parents' Details

PhilHealth Identification Number (PIN)	Father's Last Name	Father's First Name	Name Extension (JR/SR/III)	Father's Middle Name	Mark √ if with Permanent Disability	Date of Birth (mm-dd-yyyy)
					☐	

PhilHealth Identification Number (PIN)	Mother's Last Name	Mother's First Name	Name Extension (JR/SR/III)	Mother's Full Middle Name	Mark √ if with Permanent Disability	Date of Birth (mm-dd-yyyy)
					☐	

3. MEMBERSHIP CATEGORY

3. 1 Formal Economy

☐ Private ☐ Government
☐ Permanent/Regular ☐ Casual ☐ Contractor/Project-Based
☐ Enterprise Owner
☐ Household Help / Kasambahay
☐ Family Driver

3.2 Informal Economy

☐ Migrant Worker
☐ Land Based ☐ Sea Based
☐ Informal Sector (e.g. Market Vendor, Street Hawker, Pedicab/Tricycle Driver, etc.)
(Please specify): ____________________
Estimated Monthly Income: Php ____________
☐ No Income
☐ Self-Earning Individual (e.g. Doctors, Lawyers, Engineers, Artists, etc.)
(Please specify): ____________________
Estimated Monthly Income: Php ____________
☐ Filipino with Dual Citizenship
☐ Naturalized Filipino Citizen
☐ Citizen of other countries working/residing/studying in the Philippines
☐ Organized Group (Please specify): ____________

3. 3 Indigent

☐ NHTS-PR

3.4 Sponsored

☐ Local Government Unit (Please specify): ____________
☐ National Government Agency (Please specify): ____________
☐ Others (Please specify): ____________

3.5 Lifetime Member

☐ Retiree / Pensioner
☐ With 120 months contribution and has reached retirement age

Date/Effectivity of Retirement:

mm	dd	yyyy

Under the penalty of law, I attest that the information I provided in this Form are true and accurate to the best of my knowledge.

Please affix right thumbmark if unable to write.

____________________ ____________
Signature over Printed Name Date

Please do not write on this portion. For filling-out by PhilHealth Officer:

Received by: ____________________ Date: ____________

Evaluated by: ____________________ Date: ____________