Republic of the Philippines
Department of Education
Negros Island Region
SCHOOLS DIVISION OFFICE OF KABANKALAN CITY
Tayum St., Barangay 8, Kabankalan City, Negros Occidental
Tel. No. (034) 471-2003 • (034) 471-2454

DIVISION MEMORANDUM

No. 218, s. 2017

To: : All Public Schools District Supervisors/In-Charge
All Elementary and Secondary School Heads

From : **ANTHONY H. LIOBET, CESO VI**
Asst. Schools Division Superintendent
OIC-SDS

Date : **October 24, 2017**

Subject : **UPDATING OF PHILHEALTH MEMBER REGISTRATION FORM AND ER2**

The Philippine Health Insurance Corporation has since been the partner of government agencies in ensuring that employees get the most adequate medical care they need.

However, it has been a common instance for some of our employees to find discrepancies in the member's data record and thus cause delay in availing of health services.

To avoid such from reoccurring, all employees are mandated to update their personal records on a regular basis to ensure that the delivery of services will also be smooth sailing in terms of member claims.

As such, the heads of schools are hereby directed to facilitate in the updating of the personnel records in the school level using The Philhealth Member Registration Form (PMRF). Likewise, the Philhealth Report of Employee-Members using the ER2 Form which can be downloaded at https://goo.gl/MCwJMy shall be sent by school in excel format to chris.erabon@deped.gov.ph for the consolidation of reports.

Newly hired employees are also covered by the abovementioned requirements. Regular employees who already are PhilHealth members must indicate their 12-digit PhilHealth numbers in the ER2 and PMRF.

The deadline for the submission of the accomplished PMRFs and the electronic copy of the ER2 will be on November 10, 2017. It is advised that before submission, the heads of schools must ensure that these forms are properly accomplished and reflect the updated record of the employees with veracity.

Widest dissemination of this memorandum is hereby directed.

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.

_____ _____
Signature over Printed Name Date

Please affix right thumbmark if unable to write

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

Received by: _____ Date: _____

Evaluated by: _____ Date: _____

INSTRUCTIONS

1. For PURPOSE, put a mark [√] FOR ENROLLMENT if you have never been issued a PhilHealth Identification Number (PIN) or Family Health Card. Mark [√] FOR UPDATING if you want to update or make corrections to certain information previously submitted when you enrolled. Fill-out the appropriate portions of the form.
2. Please write in CAPITAL LETTERS.
3. ALL FIELDS in item 1 for Member Information ARE MANDATORY. The Member should fill-out all required information.
4. Write N.A. if the information is not applicable.
5. All name entries should be in the following format:

   Example: JUAN ANDRES DELA CRUZ SANTOS III will be entered as:

Last Name	First Name	Name Extension	Middle Name
SANTOS	JUAN ANDRES	III	DELA CRUZ

6. For the Declaration of Dependents, fill-out the names of the living spouse, children and parents in items 2.1, 2.2 and 2.3 following the same format above.

   Put a mark [√] in the box for item 2.2 if child has disability.
   Put a mark [√] in the box for item 2.3 if parent has disability.
   Please indicate FULL MOTHER'S NAME for item 2.3.

7. For declared dependents with disability, please submit a Medical Certificate indicating the details and extent of disability. As defined in the Implementing Rules and Regulations of the National Health Insurance Act of 2013, the following are included as qualified dependents:

   a. Children who are twenty-one (21) years old or above but suffering from congenital disability, either physical or mental, or any disability acquired that renders them totally dependent on the member for support.

   b. Parents with permanent disability regardless of age that renders them totally dependent on the member for subsistence.

8. For MEMBERSHIP CATEGORY, put a mark [√] in the appropriate box and specify details as necessary.
9. The member or guardian (if member is a minor) should certify that the information provided are true and correct by affixing his/her signature over the printed name in the space provided for. If unable to write, please affix the right thumbmark in the space provided.

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

Er2

SCHOOL: | Employer No:

ADDRESS: | E-MAIL ADDRESS:

PHILHEALTH NUMBER (12-digit Number)	NAME OF EMPLOYEE Surname First Name Middle name	POSITION	MONTHLY SALARY	DATE OF EMPLOYMENT	(DO NOT FILL) EFF. DATE OF COVERAGE	PREVIOUS EMPLOYER (IF ANY)

TOTAL NO LISTED ABOVE: One (1)

PAGE 1 OF 1 SHEETS

CERTIFIED CORRECT:

Human Resource Management Officer II

SIGNATURE OVER PRINTED NAME

TO BE ACCOMPLISHED IN DUPLICATE.

INSTRUCTIONS

1. An employer who is not yet registered with PhilHealth will submit this form in two (2) copies together with the "Employer Data Record ", in two (2) copies also.

2. An employer already registered with PhilHealth will submit this form in two (2) copies to PhilHealth to report (a) newly hired employee(s). The PhilHealth Number of the employee (which was shown to the Employer) should be written in the first column of this form.

3. ALL COLUMNS SHALL BE FILLED CORRECTLY, except the column with the heading "EFF. DATE OF COVERAGE".

4. IT IS IMPORTANT THAT YOU INDICATE YOUR REGISTERED NAME AND EMPLOYER NUMBER IN YOUR REMITTANCE (PhilHealth Form RF1) ACCURATELY. OTHERWISE, YOUR PAYMENTS CAN NOT BE CREDITED TO YOUR ACCOUNT.