RF-1

REVISED JAN 2008

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION

EMPLOYER'S REMITTANCE REPORT

FOR PHILHEALTH USE

Date Received: Action Taken:

By: _____
Signature Over Printed Name

1 PHILHEALTH NO. ☐☐-☐☐☐☐☐☐☐☐-☐

EMPLOYER TIN ☐☐☐-☐☐☐-☐☐☐-☐☐☐

2 COMPLETE EMPLOYER NAME _____

COMPLETE MAILING ADDRESS _____

_____

TELEPHONE NO. _____

3 EMPLOYER TYPE

☐ PRIVATE
☐ GOVERNMENT
☐ HOUSEHOLD

4 REPORT TYPE

☐ REGULAR RF-1
☐ ADDITION TO PREVIOUS RF-1
☐ DEDUCTION TO PREVIOUS RF-1

5 APPLICABLE PERIOD

_____ 200__

6 NAME OF EMPLOYEE/S				7	8	9 NHIP PREMIUM CONTRIBUTION		10 MEMBER STATUS S-Separated, NE-No Earnings, NH-Newly Hired
NO.	SURNAME	GIVEN NAME	MIDDLE NAME	PHILHEALTH NO.	MONTHLY SALARY BRACKET (MSB)	PS	ES	STATUS
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								

11 ACKNOWLEDGEMENT RECEIPT (ME-5/POR/OR/PAR)				
APPLICABLE PERIOD	REMITTED AMOUNT	ACKNOWLEDGEMENT RECEIPT NO.	TRANSACTION DATE	NO. OF EMPLOYEES

12

SUBTOTAL (PS + ES)
(To be accomplished on every page)

GRAND TOTAL (PS + ES)
(To be accomplished on the last page)

13 CERTIFIED CORRECT

SIGNATURE OVER PRINTED NAME

OFFICIAL DESIGNATION

DATE

PLEASE READ INSTRUCTIONS (FOR EACH NUMBERED BOX) AT THE BACK BEFORE ACCOMPLISHING THIS FORM

14 PAGE ____ OF ____ PAGES

INSTRUCTIONS

NOTE: Instructions for each numbered box are enumerated below

BOX 1 Write the complete Employer TIN and PHILHEALTH NO. in corresponding boxes. “if without **PEN**, the employer shall be required to attach duly accomplished ***ER1*** form and **any** of the following documents, whichever is applicable to facilitate registration and PEN issuance:

1. Business License Permit for single proprietorship;
2. SEC Registration for a partnership and Corporation;
3. License to Operate for all employers.

BOX 2 Write the COMPLETE Employer Name, Address and Telephone No. (**DO NOT ABBREVIATE**)

BOX 3 Check applicable box for the Employer Type.

BOX 4 Check the applicable box for the **Report Type.** For adjustment on remittance report on previous month, use a separate RF-1 form and check the box corresponding to "**Addition to Previous RF-1**" or "**Deduction to Previous RF-1**" as the case maybe. Write only the names of the employees with erroneous contributions and the difference between the correct amount and the amount that was previously reported. If an underpayment results due to correction, please remit the amount due to PhilHealth. Use separate/ different sets of RF-1 form for each month when reporting previous payments or late payments made on previous month(s).

BOX 5 Always indicate the applicable month and year of premium contributions paid. The month and year coverage in the RF-1 should correspond with the month and year coverage indicated in the ME-5 /OR/POR/PAR.

BOX 6 Print names of Employees in alphabetical order; write **Family Name first; Given Name** and **Middle Name** as they pronounced. For instance, the names *JULIAN SALVADOR DELA CRUZ , LILIA BERNARDO DELOS SANTOS. and MARIA LAGDAMEO DE GUIA should be written as DELA CRUZ, JULIAN SALVADOR; DELOS SANTOS LILIA BERNARDO; and DE GUIA MARIA LAGDAMEO; also, names with suffixes such as Jr., Sr., III, etc. should always be written after the family name*. Do not skip lines when listing down theIr names. Write "**NOTHING FOLLOWS**" on the line immediately following the last listed employee.

BOX 7 Indicate the corresponding PhilHealth Identification No. (PIN) opposite the respective names of your employees. I**F WITHOUT PIN, The employer shall be required to attach the properly accomplished Registration Forms (M1a) including the supporting document/s for declared dependent/s if any and ER2s** to faciliate PIN issuance and registration.

BOX 8 Indicate your employees' respective **Monthly Salary Bracket (MSB)** corresponding to the **Monthly Salary Range** where the employee’s monthly salary falls. Please refer to the **Monthly Premium Contribution Schedule** for your reference. Corresponding MSB left unaccomplished shall mean that the employee’s compensation for the particular period shall belong to the highest bracket.

BOX 9 Indicate the corresponding Personal Share (PS) and Employer Share (ES) on the boxes provided for each remittance. The total premium contribution (PS + ES) for the month must fall within the prescribed bracket.

BOX 10 In the "**Member Status**" column indicate the "**S**" if the employee is separated, "**NE**" if with no earnings and "**NH**" if employee is newly hired.

BOX 11 Supply needed information on the "**ACKNOWLEDGEMENT RECEIPTS (ME-5/POR/OR/PAR)**" boxes. Indicate in the corresponding box the acknowledgement receipts no. (i.e **ME-5 Reconciliation No**., found in the lower left portion of the ME-5 form for the month. Total Monthly Premium to be indicated opposite the applicable month coverage in the ME-5/POR/OR/PAR should also tally with the amount reflected in the RF-1).

BOX 12 Add all contribution in the **Personal Share (PS)** column and **Employer Share (ES)** column, for each month and reflect the sum in the **"Subtotal"** box for each page. Consequently, add all subtotals/page totals and reflect sum in the **"Grand Total"** box in the last sheet of the accomplished RF-1 to indicate total amount of contributions paid for the applicable month.

BOX 13 Affix signature and print complete name, designation and date of certification of authorized officer certifying the report.

BOX 14 Always indicate page number and total number of pages at each of the form.

NHIP MONTHLY PREMIUM CONTRIBUTION SCHEDULE

MSB	Monthly Salary Range	Salary Base (SB)	Total Monthly Contribution	Personal Share (PS)	Employer Share (ES)
1	P 4,999.99 and below	P 4,000.00	P 100.00	P 50.00	P 50.00
2	5,000.00 to 5,999.99	5,000.00	125.00	62.50	62.50
3	6,000.00 to 6,999.99	6,000.00	150.00	75.00	75.00
4	7,000.00 to 7,999.99	7,000.00	175.00	87.50	87.50
5	8,000.00 to 8,999.99	8,000.00	200.00	100.00	100.00
6``	9,000.00 to 9,999.99	9,000.00	225.00	112.50	112.50
7	10,000.00 to 10,999.99	10,000.00	250.00	125.00	125.00
8	11,000.00 to 11,999.99	11,000.00	275.00	137.50	137.50
9	12,000.00 to 12,999.99	12,000.00	300.00	150.00	150.00
10	13,000.00 to 13,999.99	13,000.00	325.00	162.50	162.50
11	14,000.00 to 14,999.99	14,000.00	350.00	175.00	175.00
12	15,000.00 to 15,999.99	15,000.00	375.00	187.50	187.50
13	16,000.00 to 16,999.99	16,000.00	400.00	200.00	200.00
14	17,000.00 to 17,999.99	17,000.00	425.00	212.50	212.50
15	18,000.00 to 18,999.99	18,000.00	450.00	225.50	225.50
16	19,000.00 to 19,999.99	19,000.00	475.00	237.50	237.50
17	20,000.00 to 20,999.99	20,000.00	500.00	250.00	250.00
18	21,000.00 to 21,999.99	21,000.00	525.00	262.50	262.50
19	22,000.00 to 22,999.99	22,000.00	550.00	275.00	275.00
20	23,000.00 to 23,999.99	23,000.00	575.00	287.50	287.50
21	24,000.00 to 24,999.99	24,000.00	600.00	300.00	300.00
22	25,000.00 to 25,999.99	25,000.00	625.00	312.50	312.50
23	26,000.00 to 26,999.99	26,000.00	650.00	325.00	325.00
24	27,000.00 to 27,999.99	27,000.00	675.00	337.50	337.50
25	28,000.00 to 28,999.99	28,000.00	700.00	350.00	350.00
26	29,000.00 to 29,999.99	29,000.00	725.00	362.50	362.50
27	30,000.00 and up	30,000.00	750.00	375.00	375.00

COPY DISTRIBUTION

Form	No. of Copies	1st	2nd	3rd	4th
RF-1	2	PHIC	PAYOR	X	X
ME-5	4	PAYOR	PHIC	PHIC	BANK

DEADLINE OF SUBMISSION OF FORMS

Every 15th day after the applicable month

Submit Original Copy of this duly accomplished form with the corresponding copies of the validated ME-5/ OR/POR/ PAR to the Collection Section of the respective NCR-Service Offices for payors within the NCR or to Service Offices (SOs)/PhilHealth Regional Offices (PROs) for payors outside NCR. The Duplicate copy of this form shall be the Payor’s Copy. Deadline of payment contributions shall be on the 10th day after the applicable month. Employers who fail to comply with the above requirements shall be subjected to the penalties provided under Article X, R.A.7875