



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)

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PURPOSE:

FOR ENROLLMENT FOR UPDATING

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.

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Civil Status <input type="checkbox"/> Single <input type="checkbox"/> Widow(er) <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated		Nationality	Tax Identification No.(TIN)												
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 <input checked="" type="checkbox"/> if with Disability	Date of Birth mm-dd-yyyy												
					<input type="checkbox"/>													
					<input type="checkbox"/>													
					<input type="checkbox"/>													
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 <input checked="" type="checkbox"/> if with Permanent Disability	Date of Birth (mm-dd-yyyy)												
					<input type="checkbox"/>													
PhilHealth Identification Number (PIN)	Mother's Last Name	Mother's First Name	Name Extension (JR/SR/III)	Mother's Full Middle Name	Mark <input checked="" type="checkbox"/> if with Permanent Disability	Date of Birth (mm-dd-yyyy)												
					<input type="checkbox"/>													
3. MEMBERSHIP CATEGORY																		
3.1 Formal Economy <input type="checkbox"/> Private <input type="checkbox"/> Government <input type="checkbox"/> Permanent/Regular <input type="checkbox"/> Casual <input type="checkbox"/> Contractor/Project-Based <input type="checkbox"/> Enterprise Owner <input type="checkbox"/> Household Help / Kasambahay <input type="checkbox"/> Family Driver			3.3 Indigent <input type="checkbox"/> NHTS-PR															
3.2 Informal Economy <input type="checkbox"/> Migrant Worker <input type="checkbox"/> Land Based <input type="checkbox"/> Sea Based <input type="checkbox"/> Informal Sector (e.g. Market Vendor, Street Hawker, Pedicab/Tricycle Driver, etc.) (Please specify): _____ Estimated Monthly Income: Php _____ <input type="checkbox"/> No Income <input type="checkbox"/> Self-Earning Individual (e.g. Doctors, Lawyers, Engineers, Artists, etc.) (Please specify): _____ Estimated Monthly Income: Php _____ <input type="checkbox"/> Filipino with Dual Citizenship <input type="checkbox"/> Naturalized Filipino Citizen <input type="checkbox"/> Citizen of other countries working/residing/studying in the Philippines <input type="checkbox"/> Organized Group (Please specify): _____			3.4 Sponsored <input type="checkbox"/> Local Government Unit (Please specify): _____ <input type="checkbox"/> National Government Agency (Please specify): _____ <input type="checkbox"/> Others (Please specify): _____															
			3.5 Lifetime Member <input type="checkbox"/> Retiree / Pensioner <input type="checkbox"/> With 120 months contribution and has reached retirement age															
			Date/Effectivity of Retirement: <table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td>mm</td><td>dd</td><td>yyyy</td><td> </td><td> </td><td> </td> </tr> </table>										mm	dd	yyyy			
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 do not write on this portion. For filling-out by PhilHealth Officer:															
Signature over Printed Name _____ Date _____			Received by: _____ Date: _____ Evaluated by: _____ Date: _____															

Please affix right thumbmark if unable to write.

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:

<u>Last Name</u>	<u>First Name</u>	<u>Name Extension</u>	<u>Middle Name</u>
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.