



WELCOME
SBMA
PARTICIPANTS!!!

MEMBERSHIP REGISTRATION


ON EMPLOYER REGISTRATION...



*Section 15, Rule III of the Revised IRR
specifically states the following:*

**“All government and private sector employers
are required to register with the Corporation
and each shall be issued a permanent
PhilHealth Employer Number”**

EMPLOYER REGISTRATION ER1 (2 copies)

 PhilHealth Employer No.:		Republic of the Philippines HILIPPINE HEALTH INSURANCE CORPORATION Citystate Centre 709 Shaw Boulevard, Pasig City Healthline 637-9999 www.philhealth.gov.ph		ER1 EMPLOYER DATA RECORD	
1. Name of Agency/ Office/ Department (for Gov't. Sector)/ Business/ Firm/ Employer (for private Sector)				TIN	
2. Address of Agency/ Office/ Department/ Business/ Firm / Employer				2a. Tel. No.	
3. E-Mail Address				3a. Postal Code	
4. If Regional/ Branch Office, State the name and address of Main/ Head Office		4a. Main/ Head Office/ Employer		4b. Date Operation Started	
				4c. No. of Employees	
5. Services Rendered/ Nature of Business/ Operation (for Private Sector)					
6. Type of Agency (For Gov't Sector) <input type="checkbox"/> Local <input type="checkbox"/> Corporation <input type="checkbox"/> Special Project <input type="checkbox"/> National <input type="checkbox"/> Constitutional (For Private Business/ Operation) <input type="checkbox"/> Single Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation					
I hereby certify that the above data are true and correct to the best of my knowledge and belief.					
Date		Head of Agency or Representative		Signature	
				Title or Position	
This portion is to be filled-up by PhilHealth					
Date Received:		Evaluated by:		Date Evaluation:	
		Name and Signature			

Necessary Data:

1. Name of Employer
2. Address
3. TIN
4. Authorized Representative (original signature with designation)

Supporting Document/ s:

Single Proprietorship

DTI Certificate

Form 2303 from BIR

Partnership / Corporation

SEC Certificate

Form 2303 from BIR

Cooperatives

**Cooperative Devt
Authority (CDA)
Certificate**

ISSUANCE OF PEN



General Rule :

ONE TIN, ONE PEN POLICY

- Self-remitting companies / businesses can be issued a separate PEN from their Head Office **FOR USE IN PAYING PREMIUM PAYMENT.**
- Submit Form 2303 (BIR Certification of Registration) for the branch code or make a formal request for a separate PEN **FOR USE IN PAYING PREMIUM PAYMENT.**

DEFINITION OF PEN

PEN

PhilHealth Employer Number

A set of unique 12-digit numbers assigned to each employer to be used in all transactions with PhilHealth.



CORe

EMPLOYER DATA RECORD (EDR)



Employer's Data Record

Philippine Health Insurance Corporation

PRO - III Branch A

PhilHealth Bldg., Lazatin Blvd., San Agustin, San Fernando, Pampanga

Tel. Nos. : (045) 963 7125 (045) 961 4175 (fax) (045) 963 7148 (045) 963 7149 (fax)
MICR0005

PEN

Rundate : 8/12/2008

Runtime : 4:22 PM

Printed by : 20489405

Page No. : 1

Philhealth Employer No. : **019000028174**

Employer Name : TEST CENTRALLY REMITTING OFFICES

Date Created/Edited : 23-JUN-05

Encoder/Editor : 20183499/


EMPLOYER INFORMATION

Doc. Control No. : E10623051900770
TIN Number :
Address : CITYSTATE CENTRE BLDG 709 SHAW BOULEVARD, ORANBO, PASIG CITY
Email Address : dmu.mcmg@philhealth.gov.ph
Telephone No. : 6319325
Main/Head Office :
Nature of Business : REMITTING OFFICES
Date Operation Started : 6/23/2005
Zip Code :
Employer Type : PRIVATE
Type of Business/Agency : CORPORATION
Head of Agency/Representative : DBMU PDTSS MEDMO MCMG
Title Position : CEO

ARSENIA B. TORRES

Manager

Note: This is a system-generated form, signature is not required.

TO BE ACCOMPLISHED IN DUPLICATE		PLEASE READ INSTRUCTIONS AT THE BACK	
 <div style="text-align: center;"> Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION <small>PRO ADDRESS & CONTACT NUMBER</small> </div> <div style="margin-top: 10px;"> PhilHealth Employer No. <div style="border: 1px solid black; display: flex; justify-content: space-around; width: 100px; height: 20px; margin: 5px 0;"></div> </div>		<div style="font-size: 2em; font-weight: bold; margin-bottom: 10px;">ER-3</div> EMPLOYER DATA AMENDMENT FORM April 2004	
1. Complete Name of Agency/Business/Firm/Employer			
2. Address of Agency/Business/Firm/Employer			Postal Code <div style="border: 1px solid black; display: flex; justify-content: space-around; width: 60px; height: 20px; margin: 5px 0;"></div>
3. Change/Correction of Name of Agency/Business/Firm/Employer <i>Previous :</i> _____ <i>Present :</i> _____			
4. Change/Correction of Address of Agency / Office / Department / Business / Employer <i>Previous :</i> _____ <i>Present :</i> _____			
5. Change of Legal Personality <i>From :</i> <input type="checkbox"/> Single Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Others _____ <small>Please specify</small>		6. Change of Authorized Signatory <i>Present :</i> <div style="display: flex; justify-content: space-between; margin: 5px 0;"> Name _____ Title or Position _____ Signature _____ </div> <i>Previous :</i> <div style="display: flex; justify-content: space-between; margin: 5px 0;"> Name _____ Title or Position _____ Signature _____ </div>	
7. Merger/ Consolidation of Company/ies <i>Name of Surviving Company :</i> _____ <i>Name(s) of Absorbed Company(ies) :</i> (1) _____ (2) _____ (3) _____ <small>(In case of lack of space, you may use additional sheet)</small>		8. Temporary Suspension of Operation <input type="checkbox"/> Fire <input type="checkbox"/> Demolition <input type="checkbox"/> Bankruptcy Date of Effectivity _____ <input type="checkbox"/> Separation of Employees <input type="checkbox"/> Others _____ <small>Please specify</small>	
9. Correction of Employer TIN <i>From :</i> _____ <i>To :</i> _____		10. Termination/ Dissolution of Operation <input type="checkbox"/> Merger <input type="checkbox"/> Bankruptcy Date of Effectivity _____ <input type="checkbox"/> Change of Legal Personality <input type="checkbox"/> Others _____ <small>Please specify</small>	
11. Change of Ownership <i>Reason/s:</i> _____ <i>From :</i> _____ <div style="text-align: center; margin: 5px 0;">(Complete Name)</div> <i>Date of Effectivity</i> <div style="border: 1px solid black; display: flex; justify-content: space-around; width: 100px; height: 20px; margin: 5px 0;"></div> <i>To :</i> _____ <div style="text-align: center; margin: 5px 0;">(Complete Name)</div>		12. Report on Resumption of Operation <i>Date of Effectivity</i> <div style="border: 1px solid black; display: flex; justify-content: space-around; width: 100px; height: 20px; margin: 5px 0;"></div>	
I hereby certify that the above data are correct to the best of my knowledge and belief.			
<div style="display: flex; justify-content: space-between; margin: 0;"> _____ Date _____ Head of Agency or Authorized Representative _____ Signature _____ Title or Position </div>			
THIS PORTION IS TO BE FILLED UP BY PHILHEALTH			
Received by:	Date:	Processed by:	Date:
Encoded by:	Date:	Approved by:	Date:
<small>Reqs. er3 form</small>			

Form to be
used in any
amendment /
correction in
an employer's
data
previously
submitted to
PhilHealth

**Submit ER3 (2 copies)
together with the
applicable document / s**

SAMPLE FORM

EMPLOYER AMENDMENT



I. CORRECTION / CHANGE OF BUSINESS NAME /

Submit certificate of filing of business name with the DTI or (amended) Articles of Partnership / Incorporation

CHANGE OF LEGAL PERSONALITY:

From Single Prop to Corp: Article of Incorporation duly received by SEC & Approved application of Business Retirement as Single Prop

From Partnership to Corp: Article of Incorporation duly received by SEC & Deed of Dissolution of Partnership approved by SEC

**For Change of Legal Personality
A NEW PEN WILL BE ISSUED AND THE
OLD PEN WILL BE CLOSED.**

EMPLOYER AMENDMENT



II. TEMPORARY SUSPENSION OF OPERATION (if due to):

a. **Bankruptcy**

Financial Statement or ITR or Board Resolution

b. **Separation of Employee/ s**

Latest submitted prescribed PhilHealth Form and Separation Paper of last employee

c. **Fire / Demolition / Flood**

Certification from the Fire Dept. of the Municipality or City

d. And such other fortuitous events as defined by law

EMPLOYER AMENDMENT



III. TERMINATION / DISSOLUTION:

a. Single Proprietorship

- Approved Application of Business Retirement by the Municipal Treasurer's Office **or**
- Death Certificate in case the owner dies to be submitted by a legal representative

b. Partnership / Corporation

- Deed of Dissolution approved by SEC **or**
- Minutes of the Meeting certified by the Corporate Secretary

c. Cooperative

- Certificate/ Order of Dissolution / Cancellation issued by the CDA

d. Under fortuitous events as defined by law – submit applicable documents as determined by the Corporation

EMPLOYER AMENDMENT

IV. MERGER / CONSOLIDATION:

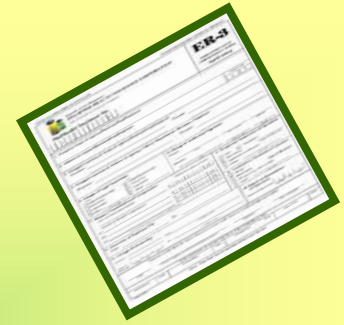
- Deed of Merger / Merger Agreement certified by SEC
- Memorandum of Agreement filed with SEC

The PEN to be used will be the PEN of the surviving / absorbing company.

V. CHANGE OF OWNERSHIP:

- a. Sale
 - Deed of Sale / Transfer / Assignment

EMPLOYER AMENDMENT



VI. RESUMPTION OF OPERATION:

- Submit prescribed PhilHealth Form reporting newly-hired or re-hired employees. In case of closure due to fortuitous events, submit applicable documents as determined by the Corporation.

NOTE : Photocopies of the documents cited above may be submitted but the original / CTC must be presented to PHIC for cross checking

ON REGISTRATION OF EMPLOYEES...

Section 18, Rule III of the Revised IRR specifically states the following:

“All government and private employers are required to register their employees with the Corporation and shall be issued a permanent and unique PhilHealth Identification Number.”

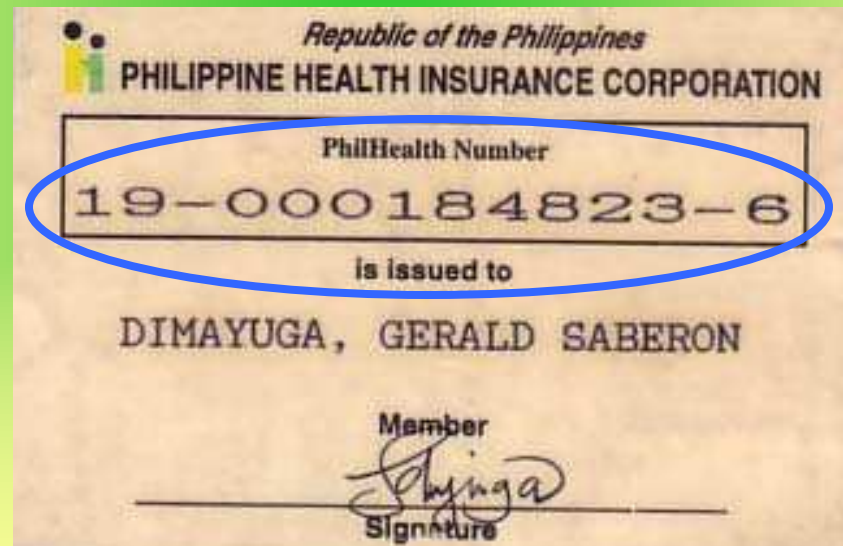
“XXX to report to the Corporation its newly-hired employees within 30 calendar days from assumption to Office”

“Further, the employer has the obligation to give notice to the Corporation of an employee’s separation within 30 calendar days from separation. Failure to remit the premium contribution shall make the employer liable for reimbursement of payment for a properly filled-up claim in case the separated employee or the dependent/ s avail of NHI P benefits without prejudice to the imposition of other penalties xxx”

DEFINITION OF PIN

PIN - PhilHealth Identification Number

This is a set of unique numbers assigned to each member to be used in all transactions with PhilHealth.



PhilHealth Number Card (PNC)

MEMBERSHIP REGISTRATION

INITIAL REGISTRATION:


- 1. Employer Data Record Form (ER1)**
- 2. Report of Employee Form (ER2)**
- 3. Member Data Record Form for Employed Sector (M1a)**

SUBSEQUENT REGISTRATION:

- 1. Report of Employee Form (ER2)**
- 2. Member Data Record Form for Employed Sector (M1a)**

EMPLOYEE REGISTRATION THE ER2

PLEASE READ INSTRUCTIONS AT THE BACK BEFORE ACCOMPLISHING THIS FORM.

 PHILHEALTH REPORT OF EMPLOYEE-MEMBERS		(CHECK APPLICABLE BOX) <input type="checkbox"/> INITIAL LIST (Attach to PhilHealth Form Er1) <input type="checkbox"/> SUBSEQUENT LIST		Er2		
NAME OF EMPLOYER/FIRM: ✓			Employer No.: ✓			
ADDRESS: ✓			E-MAIL ADDRESS:			
PHILHEALTH/SSS/GSIS NUMBER	NAME OF EMPLOYEE	POSITION	SALARY	DATE OF EMPLOYMENT	(DO NOT FILL) EFF. DATE OF COVERAGE	PREVIOUS EMPLOYER (IF ANY)
TOTAL NO. LISTED ABOVE:			PAGE ____ OF ____ SHEETS		CERTIFIED CORRECT: ✓ SIGNATURE OVER PRINTED NAME	

TO BE ACCOMPLISHED IN DUPLICATE.
Note: This form can be reproduced but is not for sale.

Necessary Data:

1. Name of Employer
2. Address
3. PEN
4. Authorized Signatory
(original signature)

Note: This form can be reproduced but is not for sale, to be accomplished in duplicate

1. Surname, First Name, Middle Name
2. Philippine Address
3. Gender
4. Date of Birth
5. Civil Status
6. Signature

DECLARATION OF DEPENDENTS



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

Member's PhilHealth Number		Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION 8/F, Philippine Heart Center Bldg. East Ave., Diliman, Quezon City		M1a <small>MEMBER DATA RECORD FOR EMPLOYED SECTOR (PARA SA MGA NAMAMASUKAN) August 1999</small>									
1. Surname (Apelyido)		Given name (Pangalan)		Middle Name (G. Apelyido)	1a. TIN _____								
2. Permanent Address (Tirahan) _____ _____					2a. Postal Code _____								
					2b. Tel. No. _____								
Number & Street / (Numero at kalye)		Barangay		Town/City [Bayan/Lungsod]	Province [Lalawigan]								
3. Sex (Kasarian)	3a. Date of Birth (Kapanganakan)		3b. Place of Birth (Lugar ng Kapanganakan)	3c. Name and Address of Office (Pangalan at lugar ng opisina)									
<input type="checkbox"/> Male (Lalaki)	<table border="1"><tr><td>[]</td><td>[]</td><td>[]</td><td>[]</td><td>[]</td><td>[]</td></tr><tr><td>m m d d y y y y</td></tr></table>		[]	[]	[]	[]	[]	[]	m m d d y y y y				
[]	[]	[]	[]	[]	[]								
m m d d y y y y													
<input type="checkbox"/> Female (Babae)													
4. Employment Classification (Uri ng Mangagawa)			4a. Civil Status (Katayang Sibilyo)										
<input type="checkbox"/> Private (Manggagawa sa Pribado) \$\$\$ No _____			<input type="checkbox"/> Single (Walang Asawa) <input type="checkbox"/> Widowed (Baloto)										
<input type="checkbox"/> Gov't (Manggagawa sa Gobyerno) GSIS Policy No. _____			<input type="checkbox"/> Married (May Asawa) <input type="checkbox"/> Separated (Hinalaya)										
If married, name of spouse: _____ Surname _____ Given Name _____ Middle Name _____													
Occupation: _____ Spouse's PhilHealth Number: _____													
D E P E N D E N T S (MGA MAKIKINABANG)													
Use back page for additional dependent(s), if necessary. (Gamitin ang kabilang pahina para sa dagdag na makikínabang, kung kinailangan.)													
PhilHealt. Number (To be filled up by PhilHealth)	Name of Dependents (Pangalan ng Makikinabang)	SEX (M or F)	Relationship of Dependents to Member (Relasyon ng Makikinabang sa Miyembro)	Date of Birth (Kapanganakan)									
	Last Name First Name MI.			mm-dd-yyyy									
<div>If child has congenital disability acquired before age 21, please attach a copy of Medical Certificate (Kung ang anak ay nagkaroon ng kapanganakan bago sumapit sa gulang na 21, ilipat ang medical certificate)</div> I hereby certify that the above statements are true and correct and further declare that the above-named dependents have not been declared by my spouse/brother/sister. (Akoy ay nagaapatunay na ang nasasa itaas na mga pahayag ay totoong tama at dahil sa pagkakataon hindi nila ipinahalagay ang mga namasing makikínabang sa itaas ay hindi inihiyag ng akoy asawa o kapatid.) Signature (Lagda) _____ THIS PORTION IS TO BE FILLED UP BY PHILHEALTH Date received: _____ Received by: _____ Name and Signature _____													

Note: This form can be reproduced but is not for sale, to be accomplished in duplicate.

Who can be your dependents?


Legitimate spouse, non-member

Children (legitimate, illegitimate, adopted and step-child) below 21 years old, unmarried and unemployed

Children above 21 years old but suffering from disability

Parents 60 years old and above
(biological, adoptive and step parent),
not qualified as non-paying member
and wholly dependent on the member
for support (including adoptive and
step parents)

MEMBER DATA RECORD (MDR)

 **Philippine Health Insurance Corporation**
PhilHealth Bldg., Lacatin Blvd., San Agustin, San Fernando, Pampanga 2000
Tel. Nos. : (045) 963 7125 (045) 963 4175 (fax) (045) 963 7148 (045) 9600020 (fax)

MEMBER DATA RECORD **PIN** **MDR**

MEMBER INFORMATION

PhilHealth Identification Number (PIN) : **190897655172**
Member Category : Private

TEST IV, TEST TEST
TI,
FAIRVIEW, QUEZON CITY

Foreign Address : N/A
Gender : Male
Date of Birth : 05/11/1974
Place of Birth : MANILA, 1ST DISTRICT METRO MANILA, FIRST DIST.
Contact No. (Foreign) : N/A
Civil Status : SINGLE
(Local) :
Tax Identification Number :

EMPLOYER/ORGANIZED GROUP INFORMATION

PhilHealth Number (PEN/POGN) : 011000000002
Name of Employer/Organized Group : TEST-ILOILO CITY SOURCE
Business Address : 111 VICENTE ST, SIMON LEDESMA, ILOILO CITY, ILOILO 5000
Telephone Number : 4551195
Tax Identification Number : 000000000001

DEPENDENT INFORMATION

No.	Surname	Given Name	Middle Name	Sex	Relation	Date of Birth
*** NO DECLARED DEPENDENT/S ***						

ARSENIA B. TORRES
Manager
PRO - III Branch A

This is a system generated report. Signature is not required.
8/12/2008 10:43 AM 20489403 ARSENIA 6/12/2003 10:11/2006

DOCUMENTARY REQUIREMENTS


FOR THE DECLARATION OF DEPENDENTS

Dependent	Proof of dependency
Child	<ul style="list-style-type: none"> ➤ Clear copy of Birth/ Baptismal Certificate wherein the name of parents is indicated therein
Illegitimate/ Legitimated Child	<ul style="list-style-type: none"> ➤ Clear copy of Birth/Baptismal Certificate of dependent reflecting the name of member as parent
Legally adopted child	<ul style="list-style-type: none"> ➤ Birth Certificate of the adopted child in w/c adoption is annotated thereto; or ➤ Clear copy of Legal Adoption papers or Court Resolution/ Decision
Stepchildren	<ul style="list-style-type: none"> ➤ Clear copy of Marriage Contract / Certificate between the member and the biological parent and ➤ Clear copy of Birth Certificate of dependent stepchild/ren

Documentary Requirements

Dependent	Proof of dependency
Spouse ➤ Muslim Spouse	<ul style="list-style-type: none">➤ Clear copy of Marriage Contract/Certificate➤ Affidavit of Marriage issued by the Office of the Muslim Affairs (OMA), passed through the Shari'a Court & must be registered/authenticated in the National Statistics Office
Parents 60 years old and above	<ul style="list-style-type: none">➤ Clear copy of Birth/Baptismal/Marriage Certificate of member and➤ Clear copy of Birth/Baptismal certificate of parents or➤ In its absence Notarized Affidavit of two disinterested persons attesting to the date of birth of parent, <u>with a Certificate of No Record from NSO or LCR, or</u>➤ Senior Citizens ID issued by OSCA – Office of the Senior Citizens Affair.


Documentary Requirements

Dependent	Proof of dependency
<p data-bbox="205 407 674 643">Stepparents 60 years old and above</p>  <p data-bbox="275 1057 737 1341">4 supporting documents are to be submitted at the same time</p>	<ol style="list-style-type: none"><li data-bbox="842 480 1871 659">1. Marriage Certificate / Contract between biological parent of the member child and the stepparent and<li data-bbox="842 683 1871 1057">2. Birth Certificate of the stepparent or in its absence, a notarized affidavit of two disinterested persons attesting to the date of birth, with a Certificate of No Record from NSO or LCR or Senior's Citizen's ID issued by OSCA, and<li data-bbox="842 1081 1871 1260">3. Birth/ Baptismal/ Marriage Certificate of the member-child indicating the name of his or her biological parent and<li data-bbox="842 1284 1871 1398">4. Death Certificate of the member's deceased biological parent.

Documentary Requirements

Dependent	Proof of dependency
Adoptive Parents 60 years old and above	<ul style="list-style-type: none">• Court Decree / Resolution of Adoption or Clear copy of Birth Certificate of the child in which the adoption is annotated thereto; and• Birth Certificate/s of adoptive parents or in its absence Notarized Affidavit of two disinterested persons attesting to the date of birth of adoptive parent, <u>with a Certificate of No Record from NSO or LCR</u> or Senior Citizen's ID issued by OSCA

Documentary Requirements

Dependent	Proof of dependency
<p data-bbox="176 354 701 586">Disabled child 21 years old and above</p> <p data-bbox="247 621 737 894">Medical Certificate will be evaluated by a Medical Officer of the Benefits Administration Section</p> 	<ul data-bbox="814 418 1818 719" style="list-style-type: none">• Original copy of Doctor's Certificate that the dependent is disabled (with description of extent of disability)• Clear copy of Birth/Baptismal Certificate of the dependent child <p data-bbox="825 743 1850 971">If dependent is a stepchild: Clear copy of Marriage Contract/Certificate between the member and biological parent & the above mentioned documents.</p> <p data-bbox="810 995 1850 1174">If dependent is an adopted child: Clear copy of Legal adoption papers & Doctor's Certificate.</p> <p data-bbox="816 1219 1822 1344"><u>Doctor's certificate should be original & within the past six months.</u></p>

MEMBER AMENDMENT

Member Data Amendment

A member may request for revision / amendment in the data, w/c was previously furnished to PhilHealth, by filling out M2 form and submits documents to substantiate the same.

TO BE ACCOMPLISHED IN DUPLICATE PLEASE READ INSTRUCTIONS AT THE BACK.

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
 709 City State Centre Building, Shaw Blvd., Pasig City

PhilHealth Identification No.
 []

M2
 MEMBER DATA
 AMENDMENT FORM
 October, 2002

1. Surname (Apelyido) _____ Given Name (Pangalan) _____ Middle Name (Gitnang Apelyido) _____

2. Address (No. & Street, Town/City, Province) [Tirahan (Numero at Kalye, Bayan/Lungsod, at Lalawigan)] _____ Postal Code _____

3. Correction / Change of Name of Member or Dependent(s) (Pagwawasto/Pagpapalit ng Pangalan ng Miyembro o Tangkili / Makikinaabang)
 From: _____ To: _____

4. Correction of Date/Place of Birth of Member or Dependent(s) (Pagwawasto ng Petsa/Lugar ng Kapanganakan ng Miyembro o Tangkili / Makikinaabang)
 From: _____ To: _____

5. Change of Civil Status (Pagpapalit ng Katayuang Sibil)
☐ From: Single (Walang Asawa) To: Married (May Asawa)
☐ From: Married (May Asawa) To: Widowed (Balo)
☐ From: Widowed (Balo) To: Married (May Asawa)
☐ From: Married (May Asawa) To: Single/Annulled (Pinawalang Bisang Kasal)
☐ From: Annulled/Single (Pinawalang Bisang Kasal) To: Married (May Asawa)

To be filled up by women only (para sa mga babae lamang)
 Maiden Name: _____
 Married Name: _____

6. Change of Address (No. & Street, Town/City, Province) [Tirahan (Numero at Kalye, Bayan/Lungsod, at Lalawigan)]
 Previous: _____ Present: _____

7. Dependent/s (Tangkili/Makikinaabang):
☐ Additional
☐ Omission due to active NHIP membership, marriage, etc.
 Surname (Apelyido) _____ Given Name (Pangalan) _____ Middle Initial (Gitnang Inisyal) _____ Sex _____ Relationship of Dependent to Member (Relasyon ng Tangkili/Makikinaabang sa Miyembro) _____ Date of Birth (Kapanganakan) m m d d y y _____

8. Change of Membership Category (Pagpapalit ng Kategoriya)
 From: ☐ Government Sector Employed
☐ Private Sector Employed
☐ Individually-Paying Member
☐ Non-Paying Member
☐ Indigent

To: ☐ Government Sector Employed
☐ Private Sector Employed
☐ Individually-Paying Member
☐ Non-Paying Member
☐ Indigent

With accompanying Form E-2 (Report of Employee-Members)

9. For Formally-Employed Only: Name of Employer: _____ Employer's Contact No. _____
 Address of Employer: _____

I hereby certify that the above statements are true and correct, and further declare that the named dependents have not been declared by my spouse / brother / sister. (Ako ay nagpapalutay na ang nasa itaas na mga pahayag ay totoo at tama at diagdag kong inihahayag na ang mga nasa ibang tangkili/makikinaabang ay hindi inihayag ng aking asawa o kapatid).

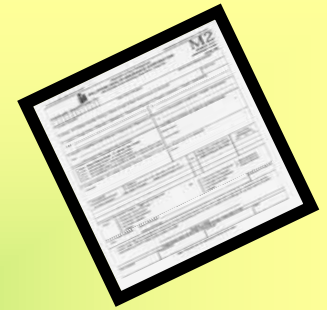
Signature (Lagda) _____

THIS PORTION IS TO BE FILLED UP BY PHILHEALTH

Date received: _____ Processed by: _____ Approved: _____ Date: _____

Note: This form can be reproduced but is not for sale.

MEMBER AMENDMENT



I. CHANGE / CORRECTION OF NAME:

Submit affidavit or Birth Certificate and Marriage Contract (if due to change of status) and surrender old PNC for replacement.

II. CORRECTION OF DATE OF BIRTH / PLACE OF BIRTH:

Submit Birth Certificate

III. CHANGE OF CIVIL STATUS:

Submit Marriage Contract/ Court Declaration on Nullity of Marriage/ Death Certificate/ Court Resolution on Presumptive Death

MEMBER AMENDMENT



IV. NEW / ADDITIONAL / CHANGE OF DEPENDENTS:

**REFER TO DOCUMENTARY REQUIREMENTS
FOR DECLARATION OF DEPENDENTS**

V. CHANGE OF ADDRESS:

**Properly accomplished Member Data
Amendment Form (M2)**

ADDITIONAL PHILHEALTH ISSUANCES

Enrollment of Foreign Nationals to the NHIP (OFFICE ORDER 0026 S-2005)

- Inclusion to NHIP the citizens of other countries residing and/or working in the Philippines.
- Enrollment shall either be through the EMPLOYED SECTOR or INDIVIDUALLY PAYING PROGRAM
- Appropriate membership forms and documentary requirements still apply but the registrant shall also submit a copy of his/her ALIEN CERTIFICATE OF REGISTRATION (ACR)

ADDITIONAL PHILHEALTH ISSUANCES

Enrollment of Foreign Nationals to the NHIP (*OFFICE ORDER 0026 S-2005*)

For declaration of dependents, documentary requirements still apply but the submitted documents must be confirmed / authenticated by the Embassy / Consulate of the country of origin of the foreign registrant

In benefit availment, the foreign-national member and/ or dependents residing in the Philippines

shall be entitled to avail of benefits only during their stay here in the Philippines.

ADDITIONAL PHILHEALTH ISSUANCES

Specific Guidelines on the Issuance of Member Data Record (MDR) to NHIP Members

Office Order No. 12, s 2008

Request for Issuance / Re-Issuance of MDR

Requirements:

- Letter of Request from the member & photocopy of the PhilHealth Number Card (PNC)
- If the PNC is not available, any valid ID to prove identity
- If the requesting person is not the member, submit an authorization letter issued by the member together with any valid ID of both the member and the authorized representative.



Why are the forms returned
without being processed?



Why are the forms returned without being processed?

CASES	REQUIREMENTS	COURSE OF ACTION
ER1 & ER2		
Signatory is different from the filled-out ER1 form & the official designation is not indicated	The Signatory of ER1 & ER2 must be similar	Return to Employer & request for Letter of Authority
Documents / Forms are photocopies / carbon copies	Original copy of ER2 with original signature of the Employer or its authorized signatories	Return to Employer
Printed Name / Signature / Title or position of Employer is not indicated in the form	Properly filled-out ER1 reflecting the printed name / signature & position of Employer / Authorized Representative	Return to Employer

Why are the forms returned without being processed?

CASES	REQUIREMENTS	COURSE OF ACTION
ER1 & ER2		
Employer Name indicated in ER2 does not match existing Employer Name in PhilHealth Database	Employer Name, PEN, address in ER2 should match the information in the PhilHealth Database	Return to Employer to verify whether it has changed its Business Name & require ER3 & applicable document. Else, replace ER2.
Same employer name, same TIN, different address	Employer Name, PEN, address in ER2 should match the information in the PhilHealth Database	Return to Employer to verify : <ul style="list-style-type: none"> - whether it is another branch. If yes, require ER1 and Form 2303 (BIR) for issuance of a separate PEN. If centrally remitting, reflect address of remitting office in ER2 & mailing address as the branch office. - whether if it's just a change of address. If yes, require ER3.

Why are the forms returned without being processed?

CASES	REQUIREMENTS	COURSE OF ACTION
M1a		
No Middle Name	Complete Middle Name	Return to Registrant thru Employer for completion of Data. If employee has no middle name, please indicate "No Middle Name" or "NMN"
Birth date of registrant reflected in the form is current year	Correct birth date of the registrant must be indicated	Return to Registrant for compliance of correct birth date
Registrant name is not included in the ER2	Name of the registrant must be included in the ER2	Return to employer for compliance

Why are the forms returned without being processed?

CASES	REQUIREMENTS	COURSE OF ACTION
<i>M1a</i>		
Any of the 6 basic data is not indicated: Member's Name, Permanent Address, Birth date, Original Signature, Sex/gender & Civil Status	All basic data must be indicated in the application form m1a for PIN assignment	Return to registrant thru the Employer for proper filling-out

Employers



For Initial Registration



**Submits Registration Forms
ER1, ER2 & M1as**



**Pay Premium
payment at
Cashier**



PhilHealth
PHILIPPINE HEALTH INSURANCE CORPORATION



Evaluates Forms submitted

Generation of PEN



Generation of PINs



Release of MDRs & PNCs

Employers



For Subsequent Registration of Employees



**Submits Registration Forms
(ER2 & M1as)**



PhilHealth

PHILIPPINE HEALTH INSURANCE CORPORATION



Evaluates Forms submitted



Generation of PINs



Release of MDRs & PNCs

RECAP MEMBERSHIP REGISTRATION

For Employers:

ER1 + Applicable Document = **PEN**

- PEN shall be released upon registration.

For Employees:

ER2 + M1a = **PIN**

- The MDRs & PNCs should be released to the employee.

RECAP ON AMENDMENT

Employer:

ER3 + Applicable Document =
Updated Employer Data Record (EDR)

Employee:

M2 + Applicable Document =
Updated Member Data Record (MDR)

**Use of PEN & PIN For Fast
& Easy Transactions.**



Sa PhilHealth



Protektado Kami!



Maraming Salamat Po!!!