AUTHORIZATION

To whom it may concern:

This is to authorize _____ to transact and claim on my
(Name of PhilHealth Dependent)
behalf the following requests:

- Amendment of PhilHealth data
- Member Data Record
- PhilHealth ID

Hoping for your consideration. Thank you.

_____
Name and Signature of PhilHealth Member

_____
Member's PIN

NOTE: Attach herewith is a photocopy of valid ID of member and representative