

REMINDERS:

1. Your PhilHealth Identification Number (PIN) is your unique and permanent number.
2. Always use your PIN in all transactions with PhilHealth.
3. For Updating/Amendment check the appropriate box and provide details to be accomplished and submit corresponding supporting documents.
4. Please read instructions at the back before filling-out this form.

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PHILHEALTH IDENTIFICATION NUMBER (PIN)

PURPOSE:

- ☐ REGISTRATION ☐ UPDATING/AMENDMENT

Preferred KonSulTa Provider

I. PERSONAL DETAILS

| | LAST NAME | FIRST NAME | NAME EXTENSION (Jr./Sr./III) | MIDDLE NAME | NO MIDDLE NAME (Check if applicable only) | MONONYM |
|-------------------------------|-----------|------------|---------------------------------|-------------|--|--------------------------|
| MEMBER | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| MOTHER'S MAIDEN NAME | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| SPOUSE (If Married) | | | | | <input type="checkbox"/> | <input type="checkbox"/> |

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|---|--|--|---|---|---|---|---|--|---|---|---|---|---|---|---|---|---|---|--|--|--|--|--|--|--|--|
| DATE OF BIRTH <table style="width: 100%;"> <tr> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> </tr> <tr> <td style="text-align: center;">m</td> <td style="text-align: center;">m</td> <td style="text-align: center;">d</td> <td style="text-align: center;">d</td> <td style="text-align: center;">y</td> <td style="text-align: center;">y</td> <td style="text-align: center;">y</td> <td style="text-align: center;">y</td> </tr> </table> | | | | | | | | | m | m | d | d | y | y | y | y | PLACE OF BIRTH (City/Municipality/Province/Country) (Please indicate country if born outside the Philippines) | PHILSYS ID NUMBER (Optional) <table style="width: 100%;"> <tr> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> </tr> </table> | | | | | | | | |
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| m | m | d | d | y | y | y | y | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SEX <input type="checkbox"/> Male <input type="checkbox"/> Female | CIVIL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Annulled <input type="checkbox"/> Married <input type="checkbox"/> Widow/er <input type="checkbox"/> Legally Separated | CITIZENSHIP <input type="checkbox"/> FILIPINO <input type="checkbox"/> FOREIGN NATIONAL <input type="checkbox"/> DUAL CITIZEN | TAX PAYER IDENTIFICATION NUMBER (TIN) (Optional) <table style="width: 100%;"> <tr> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> </tr> </table> | | | | | | | | | | | | | | | | | | | | | | | |
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II. ADDRESS and CONTACT DETAILS

| | | | | | |
|--|----------|-------------------|------------------------------------|----------|--|
| PERMANENT HOME ADDRESS Unit/Room No./Floor Building Name Lot/Block/Phase/House Number Street Name | | | | | Home Phone Number <div style="border: 1px solid black; height: 20px;"></div> |
| Subdivision | Barangay | Municipality/City | Province/State/Country (If abroad) | ZIP Code | (COUNTRY CODE + AREA CODE + TELEPHONE NUMBER) Mobile Number (Required) <div style="border: 1px solid black; height: 20px;"></div> |
| MAILING ADDRESS <input type="checkbox"/> SAME AS ABOVE Unit/Room No./Floor Building Name Lot/Block/Phase/House Number Street Name | | | | | Business (Direct Line) <div style="border: 1px solid black; height: 20px;"></div> |
| Subdivision | Barangay | Municipality/City | Province/State/Country (If abroad) | ZIP Code | E-mail Address (Required for OFW) <div style="border: 1px solid black; height: 20px;"></div> |

III. DECLARATION OF DEPENDENTS

(Use additional form if necessary)

| LAST NAME | FIRST NAME | NAME EXTENSION (Jr./Sr./III) | MIDDLE NAME | RELATIONSHIP | DATE OF BIRTH (mm-dd-yyyy) | CITIZENSHIP | NO MIDDLE NAME (Check if applicable only) | MONONYM | Check # with Permanent Disability |
|-----------|------------|---------------------------------|-------------|--------------|-------------------------------|-------------|--|--------------------------|-----------------------------------|
| | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

IV. MEMBER TYPE

| | | |
|--|---|-------------------------|
| DIRECT CONTRIBUTOR <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Employed Private <input type="checkbox"/> Employed Government <input type="checkbox"/> Professional Practitioner <input type="checkbox"/> Self-Earning Individual <input type="checkbox"/> Individual <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Group Enrollment Scheme </div> <div> <input type="checkbox"/> Kasambahay <input type="checkbox"/> Migrant Worker <input type="checkbox"/> Land-Based <input type="checkbox"/> Sea-Based <input type="checkbox"/> Lifetime Member <input type="checkbox"/> Filipinos with Dual Citizenship / Living Abroad <input type="checkbox"/> Foreign National PRA SRRV No. _____ ACR I-Card No. _____ </div> <div> <input type="checkbox"/> Family Driver </div> </div> | INDIRECT CONTRIBUTOR <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Listahanan <input type="checkbox"/> 4Ps/MCCT <input type="checkbox"/> Senior Citizen <input type="checkbox"/> PAMANA <input type="checkbox"/> KIA/KIPO <input type="checkbox"/> Bangsamoro/Normalization </div> <div> <input type="checkbox"/> LGU-sponsored <input type="checkbox"/> NGA-sponsored <input type="checkbox"/> Private-sponsored <input type="checkbox"/> Person with Disability PWD ID No. _____ </div> </div> | |
| For PhilHealth Use only: <input type="checkbox"/> Point of Service (POS) Financially Incapable <input type="checkbox"/> Financially Incapable | | |
| PROFESSION: (Except Employed, Lifetime Members and Sea-based Migrant Worker) | MONTHLY INCOME: | PROOF OF INCOME: |

V. UPDATING/AMENDMENT

| Please check: | FROM | TO |
|--|------|----|
| <input type="checkbox"/> Change/Correction of Name <small>(Last Name, First Name, Name Extension (Jr./Sr./III) Middle Name)</small> | | |
| <input type="checkbox"/> Correction of Date of Birth | | |
| <input type="checkbox"/> Correction of Sex | | |
| <input type="checkbox"/> Change of Civil Status | | |
| <input type="checkbox"/> Updating of Personal Information/Address/ Telephone Number/Mobile Number/e-mail Address | | |

Under penalty of law, I hereby attest that the information provided, including the documents I have attached to this form, are true and accurate to the best of my knowledge. I agree and authorize PhilHealth for the subsequent validation, verification and for other data sharing purposes only under the following circumstances:

- As necessary for the proper execution of processes related to the legitimate and declared purpose;
- The use or disclosure is reasonably necessary, required or authorized by or under the law; and,
- Adequate security measures are employed to protect my information.



Please affix right
thumbmark if unable to write

Member's Signature over Printed Name

Date

FOR PHILHEALTH USE ONLY

RECEIVED BY:

Full Name:

PRO/LHIO/Branch:

Date & Time:

INSTRUCTIONS

- All information should be written in UPPER CASE/CAPITAL LETTERS. If the information is not applicable, write "N/A."
- All fields are mandatory unless indicated as optional. By affixing your signature, you certify the truthfulness and accuracy of all information provided.
- A properly accomplished PMRF shall be accompanied by a valid proof of identity for first time registrants, and supporting documents to establish relationship between member and dependent/s for updating or request for amendment.
- On the PURPOSE, check the appropriate box if for **Registration** or for **Updating/Amendment** of information.
- Indicate preferred KonSulTa provider near the place of work or residence.
- For PERSONAL DETAILS, all name entries should follow the format given below. Check the appropriate box if registrant has no middle name and/or with single name (mononym).

LAST NAME

SANTOS

FIRST NAME

JUAN ANDRES

NAME EXTENSION (Jr./Sr./III)

III

MIDDLE NAME

DELA CRUZ

- Indicate registrant's/member's name as it appears in the birth certificate.
- The full mother's maiden name of registrant/member must be indicated as it appears in the birth certificate.
- Indicate the full name of spouse if registrant/member is married.
- Indicate the complete permanent and mailing addresses and contact numbers.
- For updating/amendment, check the appropriate box to be updated/amended and indicate the correct data.
- For MEMBER TYPE, check the appropriate box which best describes your current membership status.
- For Direct Contributors, except employed, sea-based migrant workers and lifetime members, indicate the profession, monthly income and proof of income to be submitted.
- For Self-earning individuals, Kasambahays and Family Drivers, indicate the actual monthly income in the space provided.
- In declaring dependents, provide the full name of the living spouse, children below 21 years old, and parents who are 60 years old and above totally dependent to the member.
- Dependents with disability shall be registered as principal members in accordance with Republic Act 11228 on mandatory PhilHealth coverage for all persons with disability (PWD).
- The registrant must affix his/her signature over printed name (or right thumbmark if unable to write) and indicate the date when the PMRF was signed.