

## **Inter-Office Memorandum**

*Reference No. HRMS 2019.02.177*

**To : ALL REGULAR EMPLOYEES**  
**From : Administrative Division**  
**Subject : I-CARE PROGRAM**  
**Date : February 5, 2019**

---

The Top Management in coordination with the Labor and Management Committee (LMC - KAISA) is pleased to announce the approval of **I-CARE PROGRAM** for all regular employees.

### **I. Introduction**

I-Care is a voluntary contribution program intended for employees' financial need involving the following purposes:

- a. Hospitalization expense due to critical/dreaded disease either of member-employee or member-employee's immediate family.
- b. Funeral or Burial expense due to sudden death either of member-employee or member-employee's immediate family.

I-Care Program is extended to member-employee's immediate family which includes spouse, children, parent/s and sibling/s whose status is single.

### **II. Scope**

I-Care is open to all regular employees who will voluntarily join the program.

### **III. Benefits of Being a Member**

I-Care member is entitled to receive the total contributed amount from all members in case a financial need occur involving either hospitalization or funeral/burial expense.

### **IV. List of Critical/Dreaded Diseases?**

Dreaded diseases generally "chronic and irreversible" conditions requiring frequent and/or prolonged hospitalization, including those requiring continuous confinement for fifteen (15) days and more.

Acceptable critical/dreaded diseases:

- a. Cerebrovascular accident (Stroke) Paralysis, epilepsy
- b. Central Nervous System lesions (Poliomyelitis, Meningitis, Encephalitis, Neurosurgical conditions)
- c. Cardiovascular disease (Coronary/Valvular/Hypertensive Heart Disease)
- d. Chronic obstructive pulmonary disease (Asthma/Bronchitis/Emphysema)
- e. Liver parenchymal disease (Cirrhosis, Hepatitis, Newgrowth)
- f. Chronic Kidney/Urological disease (Urolithiasis, Obstructive Uropathies, etc.)
- g. Chronic gastrointestinal tract disease
- h. Collagen diseases (Rheumatoid arthritis, Systemic lupus erythematosus)

- i. Diabetes
- j. Malignancies and blood dyscrasia (Cancers, Leukemia, Idiopathic Thrombocytopenic Purpura)
- k. Burns
- l. Single or multiple organ failure requiring dialysis
- m. Any illness other than above, which would require intensive care unit confinement.

## V. I-Care Application for Membership Form

- a. Fill-out the I-Care Application for Membership Form (ICAMF), signed and submit to HR.
- b. Deadline for submission of application form is every March 15.
- c. All application forms received until March 15 is valid for 1 year and renewable every year.
- d. Automatic renewal with I-Care membership shall apply to those who will not submit request for cancellation on or before March 15.
- e. Only those who haven't avail of the benefit are allowed to cancel their membership.
- f. Once you become a beneficiary or recipient of the program, automatic renewal applies unless resigned to company.
- g. The name of the immediate family member must be written in the signed and submitted ICAF for it to be honored and accepted in case a need for financial assistance occur.
- h. Application forms are available at HR and shall be emailed to all employees.

## VI. Membership Fee & Contributions

It is a FREE MEMBERSHIP but once you're a member you are required to contribute a certain amount as donation for every reported hospitalization or funeral/burial requests.

- a. **P20** if it is for hospitalization of an immediate family member of an I-Care member.
- b. **P20** if it is for burial/funeral expense of an immediate family member of an I-Care member.
- c. **P50** if it is for hospitalization of an I-Care member (regular employee).
- d. **P50** if it is for burial/funeral expense of an I-Care member (regular employee).

The above voluntary contribution is to be advanced by the company to the member-employee in need and shall be deducted on member's payroll.

The amount to be deducted may vary on the number of hospitalization or burial requests that HR will receive every month. All contributions made for the month shall be deducted to member-employee's payroll on the following month.

Ex. P20 x 2 hospitalization assistance request	= P40 deduction to salary per employee
P50 x 1 funeral/burial assistance request	= P50 deduction to salary per employee
<b>Total Deduction for the Month</b>	<b>= P90</b>

Salary deduction will only happen in months where there are received request for financial assistance.

Financial assistance granted shall be emailed to all and posted to designated bulletin board for all members' information.

## VII. Requirements

- a. Accomplished and signed I-Care Request to Avail Form (ICRAF).
- b. If the purpose of request is hospitalization expense:
  - Original Medical Certificate (with diagnosis) and
  - Original Hospital Bill (with details)

- Birth Certificate of patient-immediate family of member-employee
- CENOMAR for Siblings whose status is Single
- c. If the purpose of request is funeral/burial:
  - Death Certificate (original or certified true copy)
- d. Only the above mentioned critical/dreaded diseases are valid to request for financial assistance.
- e. Availment is one time per member/dependent per year only (1 year coverage is from April 1 to March 31).

### VIII. How to Request for Financial Assistance?

- a. Fill-out the ICRAF and signed.
- b. Forward to HR the signed ICRAF together with the required documents, receipts, certificates etc. as proof of the need for financial assistance.
- c. Processing of request for financial assistance is at least 3 working days for completed ICRAF.

### IX. Sample Computation

The total contributed amount depends on the total member-employees for the year.

Ex. 500 members x P20 = P10,000.00 [for I-Care member-employee's immediate family]  
 500 members x P50 = P25,000.00 [for I-Care member-employee]

Please be informed that effective April 1, 2019 we will no longer entertain request for a donation box since we already have this kind of program.

In case of non-members need for financial assistance due to above mentioned purpose it shall be on section discretion and responsibility.

### X. Effective Date of Implementation: April 1, 2019

### XI. Forms

1. I-Care Application for Membership Form (ICAMF) – for membership and/or cancellation of membership
2. I-Care Request to Avail Form (ICRAF) – for availing of benefit

Prepared by:

  
**ANNABELLE ARAMBULO**  
 Admin Senior Manager

Reviewed by: **YOUSUKE UENO**  
 Admin Adviser

Approved by:

  
**HIROSHI SAITO**  
 President

Noted by:

  
**RAYNAN SARNE**  
 LMC President (Management)

  
**EMILIANO FADUL JR.**  
 LMC President (Labor)

## I-CARE APPLICATION FOR MEMBERSHIP FORM

Employee Name:	BALAHADIA, TERRY MERWIN	Employee No.	174487	Date:	10-22-2020
Immediate Family Member/s					
No.	Complete Name (last name, first name, MI)	Relationship to Member (spouse, child, mother, father, sibling)	Civil Status (single, married, widow, etc.)	Age	
1	BALAHADIA, ERWIN O	FATHER	MARRIED	49	
2	BALAHADIA, MERCY C	MOTHER	MARRIED	45	
3	BALAHADIA, JAMES KERWIN C	BROTHER	SINGLE	14	
4					
5					
6					
7					
8					
9					
10					

I, BALAHADIA, TERRY MERWIN, hereby attest that the above information are true and correct. I shall submit upon request all requirements needed to verify/validate the names listed above.

CONFORME:

BALAHADIA, TERRY MERWIN  
Signature Over Printed Name

## I-CARE APPLICATION FOR MEMBERSHIP FORM

Employee Name:	BALAHADIA, TERRY MERWIN	Employee No.	174487	Date:	10-22-2020
Immediate Family Member/s					
No.	Complete Name (last name, first name, MI)	Relationship to Member (spouse, child, mother, father, sibling)	Civil Status (single, married, widow, etc.)	Age	
1	BALAHADIA, ERWIN O	FATHER	MARRIED	49	
2	BALAHADIA, MERCY C	MOTHER	MARRIED	45	
3	BALAHADIA, JAMES KERWIN C	BROTHER	SINGLE	14	
4					
5					
6					
7					
8					
9					
10					

I, BALAHADIA, TERRY MERWIN, hereby attest that the above information are true and correct. I shall submit upon request all requirements needed to verify/validate the names listed above.

CONFORME:

BALAHADIA, TERRY MERWIN  
Signature Over Printed Name

## I-CARE REQUEST TO AVAIL FORM

Member Name:	Employee No.	Date:
Dependent Name:	Relationship:	
Purpose:	<input type="checkbox"/> Hospitalization of Immediate Dependent [P20/member] <input type="checkbox"/> Funeral/Burial of Immediate Dependent [P20/member]	
	<input type="checkbox"/> Hospitalization of Member [P50/member] <input type="checkbox"/> Funeral/Burial of Member [P50/member]	
<b>Please attached the applicable Requirements:</b>		
1 <b>Accomplished and signed I-Care Request Form (ICRAF).</b>		
2 <b>If the purpose of request is hospitalization expense:</b>		
a Original Medical Certificate (with diagnosis) and		
b Original Hospital Bill (with details)		
c Birth Certificate of patient-immediate family of member-employee		
d CENOMAR for Siblings		
3 <b>If the purpose of request is funeral/burial:</b>		
a Death Certificate (original or certified true copy)		
4 <b>Only the covered critical/dreaded diseases are valid to request for financial assistance (please refer to policy) .</b>		
5 <b>Availment is one time per member/dependent per year only (1 year coverage is from April 1 to March 31).</b>		
Availed Amount:	PHP	Requested by (member):
		Approved by (HR):
--- For Accounting Use ---		
Processed by:	Reveiwed by:	Approved by:

## I-CARE REQUEST TO AVAIL FORM

Member Name:	Employee No.	Date:
Dependent Name:	Relationship:	
Purpose:	<input type="checkbox"/> Hospitalization of Immediate Dependent [P20/member] <input type="checkbox"/> Funeral/Burial of Immediate Dependent [P20/member]	
	<input type="checkbox"/> Hospitalization of Member [P50/member] <input type="checkbox"/> Funeral/Burial of Member [P50/member]	
<b>Please attached the applicable Requirements:</b>		
1 <b>Accomplished and signed I-Care Request Form (ICRAF).</b>		
2 <b>If the purpose of request is hospitalization expense:</b>		
a Original Medical Certificate (with diagnosis) and		
b Original Hospital Bill (with details)		
c Birth Certificate of patient-immediate family of member-employee		
d CENOMAR for Siblings		
3 <b>If the purpose of request is funeral/burial:</b>		
a Death Certificate (original or certified true copy)		
4 <b>Only the covered critical/dreaded diseases are valid to request for financial assistance (please refer to policy) .</b>		
5 <b>Availment is one time per member/dependent per year only (1 year coverage is from April 1 to March 31).</b>		
Availed Amount:	PHP	Requested by (member):
		Approved by (HR):
--- For Accounting Use ---		
Processed by:	Reveiwed by:	Approved by: