DEPARTMENT OF EDUCATION
EL SALVADOR CITY- RECORDS SECTION
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Republic of the Philippines
Department of Education
REGION X - NORTHERN MINDANAO
SCHOOLS DIVISION OF EL SALVADOR CITY

October 20, 2026

DIVISION MEMORANDUM
NO. 350, s. 2026

SUBMISSION OF DOCUMENTARY REQUIREMENTS FOR PHILHEALTH MEMBERSHIP UPDATING OF SOLO PARENTS AND PERSONS WITH DISABILITY (PWD)

To: Assistant Schools Division Superintendent
Chief Education Supervisor, SGOD and CID
Elementary and Secondary School Heads
All Others Concerned
This Division

1. In line with PhilHealth Circular No. 2026-0015 on the coverage of Solo Parents and their children or dependents, and PhilHealth Circular No. 2026-0017 on the coverage of Persons with Disability (PWD) under the National Health Insurance Program, all concerned personnel are hereby requested to submit the necessary documentary requirements for the updating and validation of their PhilHealth membership records.

2. The following documents shall be submitted, as applicable:

A. For Solo Parent Employees
1. Duly accomplished PhilHealth Member Registration Form (PMRF);
2. Photocopy of the front and back portions of the valid Solo Parent Identification Card (SPIC); and
3. Printed copy of the Solo Parent ID System (SPIS) record, once available.

B. For Employees with Disability (PWD)
1. Duly accomplished PhilHealth Member Registration Form (PMRF); and
2. Photocopy of the valid PWD Identification Card.

3. Please ensure that all submitted documents are complete, legible, and updated to facilitate the proper processing and updating of PhilHealth membership records. The submission of these requirements will also enable the Office to facilitate the necessary employer certification and coordination with PhilHealth, as applicable.

4. All concerned personnel are requested to submit the above documents to Personnel Section on or before **October 27, 2026**.

5. Pursuant to the cited PhilHealth Circulars, the premium contributions of qualified Solo Parent and PWD employees covered by the applicable provisions shall be shared equally by the employer and the National Government. The employer's share shall be remitted in accordance with the applicable PhilHealth premium contribution schedule, while the National Government's share shall be reflected in the system as non-collectible

from the concerned employee, subject to compliance with the prescribed documentary requirements and validation procedures.

6. Employee premium contributions deducted beginning October 2026 that are covered by the applicable subsidy provisions shall be refunded accordingly, pending the implementation of the necessary updates to the APD System, subject to applicable guidelines and the verification of the amounts deducted.

7. This Office shall adhere to the Equal Opportunity Principle (EOP) in implementing this Memorandum. All decisions and actions shall be guided by applicable policies and guidelines, without discrimination on the basis of age, gender, gender identity, sexual orientation, civil status, disability, religion, ethnicity, or political affiliation.

8. Immediate and wide dissemination of this Memorandum is hereby directed.

RANDOLPH B. TORTOLA
Schools Division Superintendent

*To be indicated in the **Perpetual Index** under the following subjects:*

Employee Benefits *Solo Parents* *Persons with Disability*

OSDS/Personnel/kbg

PhilHealth
Your Partner in Health

PMRF

PHILHEALTH MEMBER REGISTRATION FORM
UHC v.1 January 2020

PHILHEALTH IDENTIFICATION NUMBER (PIN)

EMINDERS:

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

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 (Check if applicable only)
EMBER					☐	☐
OTHER's AIDEN NAME					☐	☐
POUSE (Married)					☐	☐

ATE OF BIRTH (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)

EX
Male
Female

CIVIL STATUS
☐ Single ☐ Annulled
☐ Married ☐ Widow/er
☐ Legally Separated

CITIZENSHIP
☐ FILIPINO ☐ FOREIGN NATIONAL
☐ DUAL CITIZEN

TAX PAYER IDENTIFICATION NUMBER (TIN) (Optional)

II. ADDRESS and CONTACT DETAILS

RMANENT HOME ADDRESS
t/Room No./Floor | Building Name | Lot/Block/Phase/House Number | Street Name

odivision | Barangay | Municipality/City | Province/State/Country (If abroad) | ZIP Code

AILING ADDRESS ☐ **SAME AS ABOVE**
t/Room No./Floor | Building Name | Lot/Block/Phase/House Number | Street Name

odivision | Barangay | Municipality/City | Province/State/Country (If abroad) | ZIP Code

Home Phone Number
(COUNTRY CODE + AREA CODE + TELEPHONE NUMBER)

Mobile Number (Required)

Business (Direct Line)

E-mail Address (Required for OFW)

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 if applicable only)	Check if with Permanent Disability
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐

IV. MEMBER TYPE

DIRECT CONTRIBUTOR

Employed Private
Employed Government
Professional Practitioner
Self-Earning Individual
☐ Individual
☐ Sole Proprietor
☐ Group Enrollment Scheme
_____

☐ Kasambahay
☐ Migrant Worker
☐ Land-Based ☐ Sea-Based
☐ Lifetime Member
☐ Filipinos with Dual Citizenship / Living Abroad
☐ Foreign National
PRA SRRV No. _____
ACR I-Card No. _____

☐ Family Driver

INDIRECT CONTRIBUTOR

☐ SOLO PARENT (ID No. _____)
☐ Listahanan
☐ 4Ps/MCCT
☐ Senior Citizen
☐ PAMANA
☐ KIA/KIPO
☐ Bangsamoro/Normalization
☐ LGU-sponsored
☐ NGA-sponsored
☐ Private-sponsored
☐ Person with Disability
PWD ID No. _____

OFESSION: (Except Employed, Lifetime Members and Sea-based Migrant Worker)

MONTHLY INCOME:

PROOF OF INCOME:

For PhilHealth Use only:
☐ Point of Service (POS) Financially Incapable
☐ Financially Incapable

s form may be reproduced and is not for sale

Continue at the back

V. UPDATING/AMENDMENT

Please check:	FROM	TO
☐ Change/Correction of Name (Last Name, First Name, Name Extension (Jr./Sr./III) Middle Name)		
☐ Correction of Date of Birth		
☐ Correction of Sex		
☐ Change of Civil Status		
☐ 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.

Member's Signature over Printed Name | **Date**

Please affix right thumbmark if unable to write

FOR PHILHEALTH USE ONLY

RECEIVED BY:

Full Name: _____

PRO/LHIO/Branch: _____

Date & Time: _____

INSTRUCTIONS

1. All information should be written in UPPER CASE/CAPITAL LETTERS. If the information is not applicable, write "N/A."
2. All fields are mandatory unless indicated as optional. By affixing your signature, you certify the truthfulness and accuracy of all information provided.
3. 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.
4. On the PURPOSE, check the appropriate box if for **Registration** or for **Updating/Amendment** of information.
5. Indicate preferred KonSulTa provider near the place of work or residence.
6. 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	FIRST NAME	NAME EXTENSION (Jr./Sr./III)	MIDDLE NAME
SANTOS	JUAN ANDRES	III	DELA CRUZ

7. Indicate registrant's/member's name as it appears in the birth certificate.
8. The full mother's maiden name of registrant/member must be indicated as it appears in the birth certificate.
9. Indicate the full name of spouse if registrant/member is married.
10. Indicate the complete permanent and mailing addresses and contact numbers.
11. For updating/amendment, check the appropriate box to be updated/amended and indicate the correct data.
12. For MEMBER TYPE, check the appropriate box which best describes your current membership status.
13. For Direct Contributors, except employed, sea-based migrant workers and lifetime members, indicate the profession, monthly income and proof of income to be submitted.
14. For Self-earning individuals, Kasambahays and Family Drivers, indicate the actual monthly income in the space provided.
15. 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.
16. 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).
17. 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.