



PhilHealth Identification Number (PIN)

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|

**IMPORTANT REMINDERS:**

- Your PhilHealth Identification Number (PIN) is your unique and permanent number.
- The issuance of the PIN does not automatically qualify you or your dependents to be entitled to NHIP benefits.
- Always use your PIN in all transactions with PhilHealth.

**PURPOSE:**

FOR ENROLLMENT  FOR UPDATING

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

**1. MEMBER INFORMATION**

| Last Name  |   | First Name  |   | Name Extension (JR/SR/III) |             | Middle Name                 |  |
|--|---|---|---|----------------------------|-------------|-----------------------------|--|
| <b>If Married Female, please write FULL MAIDEN NAME:</b> |   |   |   |                            |             |                             |  |
| Last Name  |   | First Name  |   | Name Extension (JR/SR/III) |             | Middle Name                 |  |
| Date of Birth (mm-dd-yyyy)                               | Place of Birth (City/Municipality/Province) | Sex<br><input type="checkbox"/> Male<br><input type="checkbox"/> Female | Civil Status<br><input type="checkbox"/> Single <input type="checkbox"/> Widow(er)<br><input type="checkbox"/> Married <input type="checkbox"/> Legally Separated |                            | Nationality | Tax Identification No.(TIN) |  |
| <b>Permanent Address</b>                                 |   |   |   |                            |             |                             |  |
| Unit/Room No./Floor                                      |   | Building Name   |   | Lot/Block/House/Bldg. No.  |             | Street                      |  |
| Barangay   |   | City/Municipality   |   | Province                   |             | Country                     |  |
|  |   |   |   |                            |             | Zip Code                    |  |
| <b>Contact Information</b>                               |   |   |   |                            |             |                             |  |
| Landline Number (Area Code + Tel. No.)                   |   |   | Mobile Number   |                            |             | E-mail Address              |  |

**2. DECLARATION OF DEPENDENTS (Use separate sheet if necessary)**

**2.1 Legal Spouse**

| PhilHealth Identification Number (PIN) | Last Name | First Name | Name Extension (JR/SR/III) | Middle Name | Date of Birth mm-dd-yyyy | Sex M / F |
|--|-----------|------------|----------------------------|-------------|--------------------------|-----------|
|  |           |            |                            |             |                          |           |

**2.2 Children below 21 years old (unmarried & unemployed) and/or Children 21 years old and above with permanent disability**

| PhilHealth Identification Number (PIN) | Last Name | First Name | Name Extension (JR/SR/III) | Middle Name | Mark <input checked="" type="checkbox"/> if with Disability | Date of Birth mm-dd-yyyy | Sex M / F |
|--|-----------|------------|----------------------------|-------------|---|--------------------------|-----------|
|  |           |            |                            |             | <input type="checkbox"/>                                    |                          |           |
|  |           |            |                            |             | <input type="checkbox"/>                                    |                          |           |
|  |           |            |                            |             | <input type="checkbox"/>                                    |                          |           |

**2.3 Parents' Details**

| PhilHealth Identification Number (PIN) | Father's Last Name | Father's First Name | Name Extension (JR/SR/III) | Father's Middle Name      | Mark <input checked="" type="checkbox"/> if with Permanent Disability | Date of Birth (mm-dd-yyyy) |
|--|--------------------|---------------------|----------------------------|---------------------------|---|----------------------------|
|  |                    |                     |                            |                           | <input type="checkbox"/>  |                            |
| PhilHealth Identification Number (PIN) | Mother's Last Name | Mother's First Name | Name Extension (JR/SR/III) | Mother's Full Middle Name | Mark <input checked="" type="checkbox"/> if with Permanent Disability | Date of Birth (mm-dd-yyyy) |
|  |                    |                     |                            |                           | <input type="checkbox"/>  |                            |

**3. MEMBERSHIP CATEGORY**

**3.1 Formal Economy**

- Private  Government  
 Permanent/Regular  Casual  Contractor/Project-Based  
 Enterprise Owner  
 Household Help / Kasambahay  
 Family Driver

**3.3 Indigent**

- NHTS-PR

**3.2 Informal Economy**

- Migrant Worker  
 Land Based  Sea Based  
 Informal Sector (e.g. Market Vendor, Street Hawker, Pedicab/Tricycle Driver, etc.)  
 (Please specify): \_\_\_\_\_  
 Estimated Monthly Income: Php \_\_\_\_\_  
 No Income  
 Self-Earning Individual (e.g. Doctors, Lawyers, Engineers, Artists, etc.)  
 (Please specify): \_\_\_\_\_  
 Estimated Monthly Income: Php \_\_\_\_\_  
 Filipino with Dual Citizenship  
 Naturalized Filipino Citizen  
 Citizen of other countries working/residing/studying in the Philippines  
 Organized Group (Please specify): \_\_\_\_\_

**3.4 Sponsored**

- Local Government Unit (Please specify): \_\_\_\_\_  
 National Government Agency (Please specify): \_\_\_\_\_  
 Others (Please specify): \_\_\_\_\_

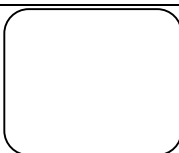
**3.5 Lifetime Member**

- Retiree / Pensioner  
 With 120 months contribution and has reached retirement age

**Date/Effectivity of Retirement:**

|    |    |  |  |  |  |      |  |
|----|----|--|--|--|--|------|--|
|    |    |  |  |  |  |      |  |
| mm | dd |  |  |  |  | yyyy |  |

Under the penalty of law, I attest that the information I provided in this Form are true and accurate to the best of my knowledge.



Please affix right thumbmark if unable to write.

Signature over Printed Name

Date

**Please do not write on this portion. For filling-out by PhilHealth Officer:**

Received by: \_\_\_\_\_ Date: \_\_\_\_\_

Evaluated by: \_\_\_\_\_ Date: \_\_\_\_\_