

ENROLLMENT FORM FOR DEPENDENTS
(For Married and Single Parent Employees Only)

INFORMATION ON EMPLOYEE:

Employee Number	Last Name	First Name	Middle Initial	Extension Name (Jr., III)
Birth Date (mm/dd/yyyy)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Civil Status <input type="checkbox"/> Married	Job Grade <input type="checkbox"/> I <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> B <input type="checkbox"/> D	Presently enrolled under Medicaid as a DEPENDENT of a current 24/7 employee? <input type="checkbox"/> YES <input type="checkbox"/> NO

- ☐ NO, I am not enrolling my dependents (i.e., parents) in the Plan. I understand that should I wish to enroll them later, I may do so only during the enrollment period prior to the start of the next contract year.
- ☐ YES, I wish to enroll my eligible dependents under the Plan. This serves as a continuing authorization for the Company to effect the semi-monthly deductions from my salary, as follows:

Membership Fees				
HIP for Extended Family Coverage				
Plan Options	Room and Board / MBL	Annual Fees	Deduction for 24 Paydays	Please choose plan Option
PLAN A	Semi-Private 60,000.00 MBL	8,500.00	354.17	
PLAN B	Regular Private 60,000.00 MBL	11,300.00	470.83	
PLAN C	Semi-Private 80,000.00 MBL	9,000.00	375.00	
PLAN D	Regular Private 80,000.00 MBL	11,400.00	475.00	
PLAN E	Regular Private 100,000.00 MBL	13,000.00	541.67	
PLAN F	Regular Private 150,000.00 MBL	14,000.00	583.33	

* The salary deduction amount represents the total premium rate that is shouldered by the employee. Premium rates may vary from year to year.

Definition of Eligible Dependents:

- Parent/s, 65 years old and below or;
- Child/ren under legal guardianship 90 days old up to 21 years old or;
- Sibling 90 days old up to 21 years old

INFORMATION ON ELIGIBLE DEPENDENTS:

Last Name	First Name	MI	Ext. (Jr., II...)	Birth Date (mm/dd/yyyy)	Age	Relationship (Mother/Father/Sibling)	Sex (M/F)	Civil Status

Guidelines for Enrolling Dependents:

1. I need to submit the following requirements in enrolling my dependents:

Requirements:

- Parents - copy of Certificate of Live Birth of parents,
- copy of my Certificate of Live Birth Certificate
Child/ren under legal guardianship – copy of Court Order/Documents of legal guardianship
Sibling – copy of certificate of live birth of sibling, one parent, and principal member's birth certificate

2. If my parents are below 60 years old and are non-PhilHealth members, I have the option to pay for the PhilHealth coverage in in order for my parents to be "Philhealth-exempt" in case they get confined in the hospital or go through a surgical procedure. A premium amounting to PhP2,700.00 will be deducted for every parent enrolled under Philhealth. Such amount will be deducted in 3 consecutive paydays after the effectivity date of my dependent/s' enrollment under the Health Insurance Plan.

- ☐ Enroll Both Parents under PhilHealth
- ☐ Not Enroll Parents under PhilHealth
- ☐ Enroll One Parent under PhilHealth - Name of Parent: _____

3. I understand that enrolling my extended family members or domestic partner is a commitment for one year. I am aware that I cannot cancel my dependents not until the renewal which is at the end of this contract year.

I certify that the information that I have provided above are true and correct to the best of my knowledge, and have followed the guidelines on dependent enrollment stated above. I understand that my providing any false information will invalidate coverage of all my dependents listed above. I authorize the Company and Medicaid to obtain a copy of all pertinent medical information in the course of my dependents' membership in the Plan.

Employee's Signature

Date

Received by OHCD / Date

DEADLINE OF SUBMISSION OF DEPENDENT FORMS IS 8 DAYS FROM YOUR START DATE OF EMPLOYMENT. EMPLOYEE SERVICES (ES) WILL NOT ACCEPT THE FORMS NOT UNLESS ALL DETAILS AND NECESSARY ATTACHMENTS ARE COMPLETE. ALL FORMS GIVEN AFTER THE DEADLINE WILL NO LONGER BE ACCOMODATED. PLEASE MAKE SURE TO HAVE THE ES SPECIALIST SIGN IN YOUR PRE-EMP CHECKLIST TO CERTIFY THAT SHE RECEIVED YOUR HIP FORM. OHCD WILL NOT BE ACCOUNTABLE FOR ANY LOST OR MISPLACED FORMS NOT SUBMITTED DIRECTLY TO THE ES SPECIALIST.