Revised 2004

Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

FAMILY ADDRESS
House No. *Street Name*
Sitio/ Village

REGION: ______________________

PROVINCE: ______________________

CITY/ MUNICIPALITY: ______________________

BARANGAY: ______________________

For PhilHealth Use

LGU: ☐ City/Municipality ☐ Province

Donor: ☐ Legislator ☐ Private

NGA (PCSO, etc)

FAMILY DATA SURVEY FORM

1	2	3				4	5	6			7		8		9
NAME (including the member)	**Relation to Member**	**FOR DISABLED DEPENDENT**				**Sex**	**Civil Status**	**DATE OF BIRTH**			**OCCUPATION**		**ACTIVE MEMBER OF PHIC**		**MONTHLY INCOME**
		Permanent		**Totally dependent to member for support**											
(Surname, First Name, Middle Initial)		**Yes**	**No**	**Yes**	**No**			**mm**	**dd**	**yyyy**	**Self-Employed**	**Employed**	**Yes**	**No**	
1.	Member														P
2.															
3.															
4.															
5.															
6.															
7.															
8.															
9.															
10.															
11.															
12.															

NAME OF RESPONDENT : ______________________

(Signature over printed name)

ADMINISTERED BY: ______________________

(Signature over printed name)

DATE: ______________

VALIDATION & RECOMMENDATION

Qualified per APCI/Endorsed ☐

Not qualified per APCI/Not Endorsed ☐

Barangay Captain LSWDO

______________________ ______________________

Signature over printed name *Signature over printed name*

TOTAL MONTHLY HOUSEHOLD/ FAMILY INCOME P

TOTAL ANNUAL HOUSEHOLD/ FAMILY INCOME *(Total Monthly Household/family Income multiplied by 12 months)* P

ANNUAL PER CAPITA INCOME (APCI) *(Total Annual Household/Family Income divided by no. of household members including head)* P

NOTE: ***Use black or blue colored ink pen. Write all in capital letters and print legibly***