RF-1

REVISED JAN 2002

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION

EMPLOYER'S QUARTERLY REMITTANCE REPORT

FOR PHILHEALTH USE

Date Screened:	Action Taken:	Date Screened:	Action Taken:
By:		By:	
Signature over Printed Name		Signature over Printed Name	

1

PHILHEALTH NO. ☐☐ - ☐☐☐☐☐☐☐☐ - ☐

EMPLOYER TIN ☐☐☐ - ☐☐☐ - ☐☐☐ - ☐☐☐

2

COMPLETE EMPLOYER NAME _____

COMPLETE MAILING ADDRESS _____

TELEPHONE NO. _____

3 EMPLOYER TYPE

☐ **Regular**
- ☐ Private
- ☐ Government

☐ **Household**

EMPLOYER'S SSS NO. ☐☐ - ☐☐☐☐☐☐☐ - ☐

EMPLOYER'S SSS/GSIS POLICY NO. ☐☐☐☐☐☐☐☐☐☐

4 TYPE OF REPORT

- ☐ Regular RF-1
- ☐ Addition to previous RF-1
- ☐ Deduction to previous RF-1

5 APPLICABLE QUARTER

- ☐ Quarter Ending Mar 200__
- ☐ Quarter Ending Jun 200__
- ☐ Quarter Ending Sep 200__
- ☐ Quarter Ending Dec 200__

6 NAME OF EMPLOYEE/S			7	8			9 NHIP PREMIUM CONTRIBUTIONS						10 REMARKS			
							1st Month		2nd Month		3rd Month		S - Separated, NE - No Earning, NH - Newly Hired			
Surname	Given Name	M.I.	PhilHealth ID No./SSS ID No./GSIS Policy No.	MONTHLY COMPENSATION BRACKET 1st Month	2nd Month	3rd Month	PS	ES	PS	ES	PS	ES	1st Month	2nd Month	3rd Month	Date of Effectivity
1																
2																
3																
4																
5																
6																
7																
8																
9																
10																
11																
12																
13																
14																
15																

11 ME-5 SUMMARY OF CONTRIBUTION PAYMENTS

Month/Quarter	Total Contribution	ME-5 Reconciliation No.	Date Paid	No. of Employees
1st Month				
2nd Month				
3rd Month				

12

SUBTOTAL **(PS + ES)** ➡

(To be accomplished on every page)

GRAND TOTAL **(PS + ES)** ➡

(To be accomplished on every page)

13 Certified Correct:

SIGNATURE OVER PRINTED NAME

OFFICIAL DESIGNATION

DATE

PLEASE READ INSTRUCTIONS (FOR EACH NUMBERED BOX) AT THE BACK BEFORE ACCOMPLISHING THIS FORM

14 Page ____ of ____ Pages

I N S T R U C T I O N S

Note: The corresponding instructions per numbered-box are enumerated below.

Box 1: Write the COMPLETE Employer TIN and PhilHealth No. in corresponding boxes.

Box 2: Write the COMPLETE Employer Name, Address and Telephone No. DO NOT ABBREVIATE.

Box 3: Check applicable box for Employer Type. Indicate the Employer's SSS No. for regular private employers. For government employers, ensure that the Employer TIN in Box 1 is filled-up. For Household employers, write Employer's SSS No./GSIS Policy No.

Box 4: Check the applicable box for Type of Report. For adjustment on remittance report of previous quarter, use a separate RF-1 form and check the box corresponding to "Addition to Previous RF-1" or "Deduction to Previous RF-1", as the case may be. Write only the names of the additional employees that were not declared or name of employees to be deleted if they were erroneously declared in the previous report. If an underpayment results due to this correction, please remit the amount due to PhilHealth . Use separate/different set of RF-1 form for each quarter when reporting previous payments or for late payments made on previous quarter(s).

Box 5: Always indicate the applicable quarter and year, of premium contributions paid by checking the box opposite the applicable quarter ending. The month coverage in the RF-1 should correspond with the month coverage indicated in the ME-5. Eg., Ms. D remitted P375 for premium due for January 2000, P375 for February 2000, and P375 for March 2000, check the box opposite the quarter ending March and indicate the amount of contribution for each column (i.e., amount remitted for January in the 1st Month; February for the 2nd month & March for the 3rd Month) in Box 9.

Box 6: Print the names of Employees/Househelpers in Alphabetical order, surname first. Write Family Names as they are pronounced. For instance, the names JULIAN DELA CRUZ, LILIA DELOS SANTOS and MARIA DE GUIA should be written as DELA CRUZ, JULIAN; DELOS SANTOS, LILIA and DE GUIA, MARIA. Also, names with suffixes such as Jr., Sr., III, etc. should always be written after the family name. Do not skip lines when listing down their names. Write "NOTHING FOLLOWS" on the line immediately following the last listed employee/househelper.

Box 7: Indicate the corresponding PhilHealth Identification No. (PIN) opposite the respective names of your employees/househelpers to ensure that all contributions paid will be credited to them. IF WITHOUT PIN, INDICATE THEIR SSS/GSIS NO.

Box 8: The monthly premium contribution of an employee is based on his actual monthly compensation. Write your employees' respective Monthly Compensation Bracket according to their actual monthly compensation for the given quarter. The monthly compensation bracket, is determined by the monthly salary range, the employee's actual monthly compensation belongs. Please refer to the Revised NHIP Monthly Contribution Schedule. Ex., Ms. R received P4,350.00 for October 2000, P4,750 for November 2000 and P4,350.00 for December 2000 so her compensation for the 1st month (October) falls in bracket 3, falls in bracket 4 for Novemberand falls in bracket 3 for December.

Box 9: Indicate corresponding Personal Share (PS) and Employer Share (ES) on the boxes provided per monthly remittance . The total premium contribution (PS + ES) for each month must fall within the prescribe salary bracket. Ex. If Ms J's monthly compensation bracket for the months of October, November and December are 4, 4, and 5 respectively, her Personal Share (PS) for October should be P56.25, P56.25 for November and 62.50 for December.The Employer Share (ES) shall also be P56.25 for October, P56.25 for November and P62.50 for December.

Box 10: In the "REMARKS" column indicate "S" if employee is separated, "NE" if with no earnings and "NH" if employee is newly hired including date of separation, period/date when the employee had no earnings and date of hiring respectively.

Box 11: Supply needed information on the "ME-5 Summary of Contribution Payments". Indicate the corresponding ME-5 Reconciliation No., found in the lower left portion of the ME-5 form, for each month. Total monthly premium to be indicated opposite the applicable month coverage in the ME-5 should also tally with the amount reflected in the RF-1.

Box 12: Add all contributions in the personal share (PS) column and employer share (ES) column, for each month and reflect the sum in the "Subtotal" box for each page. Consequently, add all Subtotals/Page totals and reflect sum in the "Grand Total" box in the last sheet of the accomplished RF-1 to indicate total amount of contributions paid for the applicable quarter.

Box 13: Affix signature and print complete name, designation and date of certification of authorized officer certifying the report.

Box 14: Always indicate page number and total number of pages at each page of the form.

Submit Orignal Copy of this duly accomplished form every quarter ending March, June, September and December with the corresponding copies of the validated ME-5 to the Contribution Accounts Management Department for payors within the NCR or to Service Offices/PhilHealth Regional Offices (PROs) for payors outside NCR. The Duplicate Copy of this form shall be the Payor's Copy. Deadline of payment of contributions shall be on the 10th day of the month following the applicable month. Employers who fail to comply with the above requirements shall be subjected to the penalties provided under Article X, R.A. 7875. Please submit this report every quarter ending only.

COPY DISTRIBUTION

Form	No. of Copies	1st	2nd	3rd	4th
RF-1	2	PHIC	Payor	X	X
ME-5	4	Payor	PHIC	PHIC	Bank

SUBMISSION OF FORMS

Appicable Quarter	Deadline of Submission
January - March	April 15
April - June	July 15
July - September	October 15
October - December	January 15

2000 NHIP MONTHLY PREMIUM CONTRIBTUION SCHEDULE & MONTHLY COMPENSATION BRACKET

Monthly Salary Bracket	Monthly Salary Range	Salary Base (SB)	Total Monthly Contribution	Personal Share (PS) (PS=SB x 1.25%)
1	P 3,499.99 and below	P3,000.00	P 75.00	P 37.50
2	3,500.00 to 3,999.99	3,500.00	87.50	43.75
3	4,000.00 to 4,499.99	4,000.00	100.00	50.00
4	4,500.00 to 4,999.99	4,500.00	112.50	56.25
5	5,000.00 to 5,499.99	5,000.00	125.00	62.50
6	5,500.00 to 5,999.99	5,500.00	137.50	68.75
7	6,000.00 to 6,499.99	6,000.00	150.00	75.00
8	6,500.00 to 6,999.99	6,500.00	162.50	81.25
9	7,000.00 to 7,499.99	7,000.00	175.00	87.50
10	7,500.00 to 7,999.99	7,500.00	187.50	93.75
11	8,000.00 to 8,499.99	8,000.00	200.00	100.00
12	8,500.00 to 8,999.99	8,500.00	212.50	106.25
13	9,000.00 to 9,499.99	9,000.00	225.00	112.50
14	9,500.00 to 9,999.99	9,500.00	237.50	118.75
15	10,000.00 and up	10,000.00	250.00	125.00

THIS FORM MAY BE REPRODUCED