Republic of the Philippines
Department of Education
Region V-Bicol
SCHOOLS DIVISION OFFICE OF LIGAO CITY

20926098

MEMORANDUM

TO: Asst. Schools Division Superintendent
Chief Education Supervisors (CID and SGOD)
All Public Elementary and Secondary School Heads
All SDO Unit/Section Heads
All Others Concerned

FROM: **NYMPHA D. GUEMO**
Schools Division Superintendent

SUBJECT: **SUBMISSION OF ANNEX A (MEDICAL ALLOWANCE REGISTRATION FORM) FOR THE PROCESSING OF THE MEDICAL ALLOWANCE FOR FY 2026**

DATE: February 9, 2026

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1. In compliance to DepEd Memorandum DM-OUHROD-2026-0160 titled Instructions on the Implementation and Immediate Processing of the Medical Allowance for Fiscal Year 2026, this Office is hereby calling for the submission of the Annex A (Medical Allowance Registration Form) of all eligible personnel in SDO Ligao City for payment through payroll disbursement.

2. Personnel who are already in the service and who are expected to render at least a total or aggregate of six (6) months of service within FY 2026 shall be eligible for the Medical Allowance. Newly-hired personnel shall be eligible only after rendering six (6) months of service.

3. All eligible personnel must submit Annex A (Medical Allowance Registration Form) indicating their *chosen individual mode of availment* to the Administrative Services Unit **on or before February 20, 2026** in bunch and by school. All schools are requested to prepare a Summary List of eligible personnel indicating the name, position title, number of years in service and chosen individual mode of availment of the eligible teaching and non-teaching personnel duly signed by the School Principal.

4. Likewise, all FY 2025 eligible personnel who availed of the Individual form of availment through *payroll disbursement* in the previous year are hereby required to liquidate and submit any but not limited to the following reportorial requirements on or before February 20, 2026. Failure to comply shall result in the withholding of the personnel's FY 2026 Medical allowance.
   a. Copy of HMO agreement;
   b. Valid ID issued by the HMO provider reflecting the name of the employee;
   c. Official receipt for the payment of the membership fee for the HMO product;

5. Employees may opt to avail of medical services or HMO packages through duly registered employee cooperatives or associations. No Official or employee shall coerce, compel or unduly influence any personnel to avail of services from any HMO provider.

6. To further improve implementation and for the enhancement of the policy, employees and FOs are encouraged to provide feedback on the FY 2025 Medical Allowance implementation accessible via https://tinyurl.com/DO16FeedbackPersonnel

7. For the information, guidance and strict compliance of all concerned.

Annex A
Medical Allowance Registration Form

Data Privacy Notice: The Department of Education recognizes its responsibility under the Republic Act No. 10173, otherwise known as the *Data Privacy Act of 2012*, with respect to the data they collect, record, organize, update, use, consolidate or destruct from their personnel. The personal data obtained from this form is entered and stored within the organization's authorized information and communications system and will only be accessed by authorized personnel. The organization has instituted appropriate technical and physical security measures to ensure the protection of personal data.

Furthermore, the information collected and stored in the portal shall only be used for the purposes of this activity. DepEd shall not disclose any personal information without consent and shall retain this information over a period of (10) ten years for the effective implementation and management of its activities.

Section 1: Employee Information

Full Name: _____
Employee ID Number: _____
Position/Designation: _____
Office: _____
Date of Appointment (dd/mm/yyyy): _____

Sex: ____ Date of Birth (dd/mm/yyyy): _____
Mobile Number: _____ Email: _____

For teaching personnel
Region: _____
Division: _____
School: _____
Employment Status: ☐ Permanent ☐ Contractual
☐ Casual ☐ Substitute

Section 2: Form of Availment

*Kindly select **one**:*

Group

☐ Agency Procurement

Individual

☐ Payroll Disbursement for availment of new/renewal of individual HMO

☐ Cash form for payment of medical expenses

Section 3: Certification

I hereby confirm that the information provided above is accurate and truthful. I agree to comply with the terms and conditions outlined in the Guidelines on the Grant of

medical allowance to DepEd personnel, including the submission of required documents for verification and processing.

Employee's Signature: _____ **Date:** _____