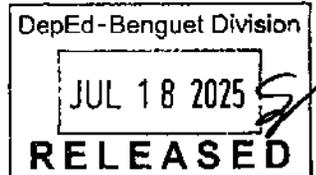




Republic of the Philippines  
Department of Education  
Cordillera Administrative Region  
**Schools Division of Benguet**



July 17, 2025

Division Memorandum

No: 247, 2025

**GRANT OF CY 2025 MEDICAL ALLOWANCE TO ELIGIBLE EMPLOYEES**

To: SDO Personnel  
Public School Heads  
School Teaching and Non-Teaching Personnel  
All others Concerned

1. In accordance with DepEd Order NO. 016 s.2025 titled "Guidelines on the grant of Medical Allowance to DepEd Personnel", this office hereby directs all eligible employees to accomplish the attached Medical Allowance Registration Form (Annex A) and indicate their preferred mode of availment, as follows:
  - a. **Group Availment** - through procurement of HMO-type benefits, facilitated by the Schools Division Office for Non-Implementing Units and School procurement for Implementing Units.
  - b. **Individual Availment**
    - b.1 Payroll disbursement for new or renewal of individual HMO Plans.
    - b.2 Cash form for payment of medical expenses
2. For individual availment, the required documents be submitted to the personnel section:
  - 2.a For new or renewal of individual HMO Plans**
    - a. Copy of HMO agreement
    - b. Valid identification card (ID) issued by the HMO provider bearing the employee's name; or
    - c. Official receipt of HMO membership payment
  - 2.b For Cash form for payment of medical expenses**
    - a. Signed Individual Cash claim form, thereto attached as Annex B
    - b. Certification of Geographically Isolated and Disadvantaged Areas (GIDA) or no certification of No Adequate HMO branch or office, or proof of denial from any HMO including to but not limited to letter or electronic mail.
3. Personnel covered as supplemental members or dependents under a family HMO plan must present valid proof of enrollment. Allowance will be granted upon submission of such documentation.
4. Personnel who availed of the cash form for payment of medical expenses are required to submit reportorial requirements subject to usual accounting and auditing rules and regulations. Failure to comply shall result in the withholding of the personnel's medical allowance for the succeeding year until such obligations have been satisfactorily settled.

5. To consolidate records for both group and individual availment, all concerned employees must complete the survey form and upload accomplished Medical Allowance Registration Form (Annex A) via the link provided in the list of eligible employees: <https://tinyurl.com/BenguetMedAllow> **or before July 25, 2025.**
6. Immediate dissemination and strict compliance with this memorandum are directed.

  
**ESTELA P. LEON-CARIÑO EDD, CESO III**  
Regional Director and  
Concurrent Officer-in-Charge  
Office of the Schools Division Superintendent

**DepED**  
MATATAG



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**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: \_\_\_\_\_ DepEd 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: \_\_\_\_\_

**Annex B**  
Individual Cash Claim Form

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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: \_\_\_\_\_  
 Service Duration: (From - To) \_\_\_\_\_  
 Sex: \_\_\_\_\_ Date of Birth (dd/mm/yyyy): \_\_\_\_\_  
 Mobile Number: \_\_\_\_\_ DepEd Email Add: \_\_\_\_\_

*For Teaching Personnel*

Region: \_\_\_\_\_  
 Division: \_\_\_\_\_  
 School: \_\_\_\_\_  
 Employment Status:  Permanent  Contractual  
                                    Casual  Substitute

**Section 2: Pre-requisite Requirements**

Supported with applicable documents, check any of the following condition below that applies:

- GIDA Certification
- Certification of area with no HMO
- Letter or email from HMO denying the application

**Section 3: Details of Medical Expenses Incurred**

Name of Medical Provider/Faculty <i>(Please add rows as necessary)</i>	Address	Date(s) of Medical Consultations/Service

<b>Description of Expense (Please Specify)</b>	<b>Amount (in PHP)</b>	<b>Receipt No./Reference</b>

*Please attach original receipts*

**Section 3: Certification**

I, the undersigned, hereby certify that the information provided in this claim form is true and correct to the best of my knowledge, and the medical expenses listed above were incurred for legitimate medical purposes. I understand that submission of false claims shall be subject to disciplinary action and other legal consequences as determined necessary by the Department of Education.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_