



Republika ng Pilipinas
LUNGSOD NG MAKATI

OFFICE OF THE MAYOR
MAKATI ACTION CENTER

Date: _____

AUTHORIZATION

This is to authorize _____ of Barangay **BEL-AIR**,
MAC Coordinator to submit my **Yellow Card** to the Office of the Makati Health Program (MHP)
and facilitate its processing and renewals.

PRINTED NAME AND SIGNATURE

Address: _____

Contact No.: _____

For MAC use only:

REQUIREMENTS FOR NEW & RENEWAL APPLICANT:

- ☐ Latest COMELEC VOTERS CERTIFICATION
- ☐ OLD MHP Yellow Card (for renewal applicant only)
- ☐ Philhealth Member Data Record (MDR) AND
 - Updated O.R. (*Proof of Payment*)-for voluntary member
 - Certification of Contribution/Payslip (*if employed in private company*)
 - Updated Online Premium Contribution (*screenshot printed copy*)
 - Acknowledgement Receipt (*Philhealth ng Masa*)
- ☐ Senior White Card and Blu Card (photocopy front and back)
- ☐ Real Property Tax Title and Latest Tax Receipt (for Senior Permanent Card)
- ☐ Long Brown Envelope

Interviewed by: _____
Printed Name and Signature -MAC Coordinator

Checked by: _____
Printed Name and Signature -MAC Team Leader

ACKNOWLEDGEMENT RECEIPT

NAME: _____ DATE: _____

CLAIM DATE: _____

SIGNATURE: _____
MAC REPRESENTATIVE



CITY GOVERNMENT OF MAKATI
MAKATI HEALTH PLUS PROGRAM



APPLICATION FORM

PRIVACY NOTICE

The personal data collected shall only be used for yellow card ID registration and shall be shared to Copied ng Makati, Makati Life, Planet Drugstore, Barangay Health Centers and Makateen Card for purposes of ID verification. You may choose to withdraw your consent by writing a request to opt out address to makati@makati.gov.ph. We are committed in protecting and respecting your privacy. If you want to know more about how we collect, use, store, and protect your personal data you may read our Privacy Notice posted in front of MSWID offices or you can request a copy of Privacy Notice from 5th Floor, MSWID Office.

MAKATI HEALTH PLUS INFORMATION SHEET

MAKATI HEALTH PLUS TYPE: <input type="checkbox"/> SOLID <input type="checkbox"/> FAMILY <input type="checkbox"/> SENIOR CITIZEN		WHO WORK/OWN: <input type="checkbox"/> SOLID <input type="checkbox"/> FAMILY <input type="checkbox"/> SENIOR CITIZEN		PERMANENT: <input type="checkbox"/> WITH LAND TITLE <input type="checkbox"/> AGE (20 YRS. OLD & ABOVE) <input type="checkbox"/> RETIRED <input type="checkbox"/> MISC. EMPLOYEE	
ADDRESS: LAST NAME FIRST NAME MIDDLE NAME		DATE APPLIED: _____			
SEX: _____	CIVIL STATUS: _____	DATE OF BIRTH: _____	AGE: _____	BLOOD TYPE: _____	
TEL. NO./CELL. NO.: _____	HOUSE: <input type="checkbox"/> OVERSEA <input type="checkbox"/> RECENT <input type="checkbox"/> LIVING WITH JOINTWIFE <input type="checkbox"/> IT/EMIGRANT	BANKING: _____			
E-MAIL ADDRESS: _____	BANK/TELECOM ID NO.: _____				
GCASH NO: _____					

SWORN STATEMENT:

This I am not confined nor one of my dependents as I signed my Affidavit (Duly) and filed a case and corresponding before court promissory note in the said hospital.

Applicant's Signature over Printed Name		With Interviewer's Signature over Printed Name				
NAME OF DEPENDENTS	RELATIONSHIP	SEX	DATE OF BIRTH	AGE	NAME OF REGION	EDUCATIONAL ATTAINMENT

DATA PRIVACY CONSENT

In accordance with the Data Privacy Act of 2012 (DPA), its Implementing Rules and Regulations and all other applicable laws, I hereby consent to the following:

1. Collection of my personal data
2. Use of my personal data for purposes and in accordance with the MSWID-MHRP Privacy Notice
3. Storage and retention of my personal data for a reasonable and necessary period as specified.
4. Sharing of my personal data for Registration and distribution of Yellow Card.

I also declare that I have read this form as well as the Privacy Notice and understood its contents. I understand that my consent does not preclude the existence of other criteria for lawful processing of personal data and does not waive any of my rights under the DPA and other applicable laws.

Signature Over Printed Name		Date	
HOME VISITATION (for MAC Interviewers only): <input type="checkbox"/> Mutual Residents <input type="checkbox"/> No Resident Resident <input type="checkbox"/> Unemployed <input type="checkbox"/> Employed in _____ with monthly _____ or daily income _____		DATE OF NOTICE TO CLAIM: MONTH _____ DAY _____ YEAR _____	
APPLICANT'S OR CANDIDATE'S Signature Over Printed Name		MAC INTERVIEWER Signature Over Printed Name	
APPROVED BY:		HOME VISITATION-IN-CHARGE Signature Over Printed Name	

Approved by: **MARIBEL M. LUMANG, RSW**
OFFICIAL-DC RANGER

Health Project of **MAYOR MARIA LOURDES NANCY S. BINAY**
AND CITY COUNCIL.