Republic of the Philippines
Supreme Court
Office of the Court Administrator
Manila

OCA CIRCULAR NO. 240-2025

TO : ALL JUDGES, OFFICIALS, AND EMPLOYEES OF THE FIRST- AND SECOND- LEVEL COURTS

SUBJECT : COMPREHENSIVE HEALTH CARE PLAN FOR THE JUDICIARY

Effective **July 8, 2025**, the ***Kaiser International Healthcare Group, Inc. and Manila Bankers and General Assurance*** (Kaiser and Manila Bankers Joint Venture) is the Health Care Provider for all incumbent Supreme Court, Court of Appeals (CA), Court of Tax Appeals (CTA), and Sandiganbayan (SBN) Justices; Judges from the First- and Second- Level courts; and all officials and employees in all court levels, for a period of one (1) year.

Additionally, the following "**dependents**" may be covered by the Comprehensive Health Care Plan for the Judiciary, **on a voluntary basis**, *provided* that they pay their corresponding premium *directly* to the Health Care Provider within two (2) months from the start of the contract:

1. Contractual employees of the First- and Second- Level courts;
2. Spouse of incumbent Judges;
3. Compulsorily-retired Judges up to the last day of age eighty (80);
4. Judges who availed of optional retirement, but only up to the last day of age sixty-nine (69), *provided* that their age at the time of retirement is not below sixty (60) years;
5. Compulsorily-retired officials and employees up to the last day of age sixty-nine (69);
6. Officials and employees who availed of optional retirement, but only up to the last day of age sixty-nine (69), *provided* that their age at the time of retirement is not below sixty (60) years; and
7. Qualified dependents of incumbent Judges, officials, and employees (as defined by PhilHealth).

All the foregoing *dependents* may enroll their membership **on or before September 08, 2025,** using the *Health Care Program Membership Application* Form (**Annex "A"**).

All applications should be submitted *directly* to the Health Care Provider.

For further details, kindly refer to the attached guidelines for eligibility, other requirements, and the process/steps for the said enrollment (**Annex "B"**).

For the information and guidance of all concerned.

July 15, 2024

LILIAN C. BARRIBAL-CO
Assistant Court Administrator and Officer-in-Charge
Office of the Court Administrator
Per Memorandum Order No. 62-2025 dated June 13, 2025

KAISER INTERNATIONAL
HEALTHGROUP INC

UNIFIED JUDICIARY
PREMIUM RATES FOR DEPENDENTS

Enrollment of Dependents:

a. Contractual employees of the SC, Appellate Courts, and LC's;
b. Spouse of incumbent Justices and Judges;
c. Compulsory-retired Justices up to the last day of age eighty-five (85);
d. Justices, who availed of optional retirement, but only up to the last day of age eighty-five (85), provided that their age at the time of retirement is not below sixty (60) years;
e. Compulsory-retired Judges up to the last day of age eighty (80);
f. Judges who availed of optional retirement, but only up to the last day of age sixty-nine (69), provided that their age at the time of retirement is not below sixty (60) years;
g. Compulsory-retired officials and employees up to the last day of age sixty-nine (69);
h. Officials and employees who availed of optional retirement, but only up to the last day of age sixty-nine (69), provided that their age at the time of retirement is not below sixty (60) years; and
i. Qualified dependents of incumbent Justices, Judges, officials and employees (as defined by Philhealth)

Enrollment of membership shall be done at the start of the contract year and their membership shall be effective until the end of the contract year.

Enrollment of membership shall be done within two (2) months **(July 08, 2025 up to September 08, 2025)** from the start of the contract year. Coverage shall start from the date of the effectivity of the contract and shall continue until the end of the contract year unless they reach the age limits.

AMOUNT OF PREMIUM *(Annual Payment Only)*		**BENEFIT LIMIT**
Php48,988.50	-	Php350,000.00

ELIGIBILITY FOR DEPENDENTS:

FOR SINGLE MEMBERS/EMPLOYEES:

► Parents of the principal member, up to age 65, unemployed and dependent upon the principal member.

► Brothers and sisters 1 year old up to 21 years of age, unemployed and are living under the same roof as the principal member.

►Enrollment of dependents must follow an order of hierarchy; the parents must be enrolled first followed by the eldest sibling and so on.

REQUIREMENTS FOR QUALIFIED DEPENDENTS:

a. NSO/PSA Birth Certificate of Parents
b. NSO/PSA Birth Certificate of Members/Employees
c. NSO/PSA Birth Certificate of Siblings

FOR MARRIED MEMBERS/EMPLOYEES:

► The legal spouse of the principal member is at least 18 years old up to age 65.

► Legitimate and/or legally adopted children 1 year old up to 21 years of age and living under the same roof as the principal member.

►Enrollment of dependents must follow an order of hierarchy; the spouse must be enrolled first followed by the eldest children, second child and so on for married personnel.

REQUIREMENTS FOR QUALIFIED DEPENDENTS:

a. NSO/PSA Marriage Certificate of Members/Employees
b. NSO/PSA Birth Certificate of Children

Guidelines for Enrollment:

Step 1 - Fill-up completely the Kaiser Application form duly signed by the Principal Member

Step 2 - Email the scan copy of duly signed application form together with the requirements (*such as NSO/PSA Birth Certificate and / or Marriage Contract)* to underwriting.supervisor@kaiserhealthgroup.net

Step 3 - A billing statement will be provided once the application is approved.

Step 4 - Proceed to payment of the premium

Payment directly to Kaiser Bank Accounts:

Account Name	:	Kaiser International Healthgroup, Inc.
Landbank - Current Account	:	1782-1042-48
BPI - Current Account	:	3711-0062-13
BDO - Savings Account	:	00428-0021-263
UnionBank - Current account	:	00203-000845-1

Step 5 - Scan and email the copy of deposit slip to billing.supervisor@kaiserhealthgroup.net

Step 6 - Issuance of the Kaiser HMO Cards

Note: Please wait for the issuance of billing statement before proceeding for payment.

KAISER INTERNATIONAL
HEALTHGROUP INC

HEALTH CARE PROGRAM MEMBERSHIP APPLICATION

I hereby apply for membership in the Health Care Program of Kaiser International Healthgroup, Inc. (Kaiser) describe herein subject to the Contract Provisions set forth in this Application. I agree that this Application and my declarations and answers below, written by me or under my direction, shall be the basis, and deemed part of the contract between Kaiser and myself.

Family Name	First Name	Middle Name	Age	Gender

Date of Birth (mm/dd/yy)	Place of Birth	Height	Weight

Address No. of Home	Street	Brgy	City	Province

Home Tel. No.	Office Tel. No.	Mobile No.	Email	GSIS ID No.	SSS ID No.

Civil Status	Occupation	Company Name	Position

Plan Type	☐ Individual	☐ Family	Plan Name	Premium

Contact person in case of emergency?	Contact No. :

INFORMATION OF DEPENDENTS UNDER INDIVIDUAL AND FAMILY PLAN

DEPENDENT 1

Last Name _____ First Name _____ Middle Name _____ Relation to Principal _____

Address _____ Date of Birth _____

Gender _____ Civil Status _____ Height _____ Weight _____ Occupation _____

Telephone _____ Mobile No. _____

DEPENDENT 2

Last Name _____ First Name _____ Middle Name _____ Relation to Principal _____

Address _____ Date of Birth _____

Gender _____ Civil Status _____ Height _____ Weight _____ Occupation _____

Telephone _____ Mobile No. _____

DEPENDENT 3

Last Name _____ First Name _____ Middle Name _____ Relation to Principal _____

Address _____ Date of Birth _____

Gender _____ Civil Status _____ Height _____ Weight _____ Occupation _____

Telephone _____ Mobile No. _____

MEDICAL REFERENCES (PRINCIPAL)

Please provide information or explanatory notes for every question with a YES answer.

1. Have you ever been treated for or ever had any known indication of:
   a. Disorder of eyes, ears, nose, or throat? NO_____ YES _____
   b. Dizziness, fainting, convulsions, headache, speech defect paralysis or stroke, mental or nervous disorder? NO_____ YES _____
   c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder? NO_____ YES _____
   d. Diabetes thyroid or other endocrine disorder? NO ___YES ___
   e. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or any other disorder of the heart or blood vessles? NO_____ YES _____
   f. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, diverticulitis, colitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach intestine, liver or gall bladder? NO_____ YES _____
   g. Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate or reproductive organs? NO_____ YES _____
   h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, such as spine, back or joints? NO_____ YES _____

i. Deformity, lameness or amputation? NO___ YES___

j. Disorder of skin, lymph glands, cysts, tumor or cancer? NO___ YES___

k. Allergies, anemia or other disorder of the blood? NO___ YES___

l. Excessive use of alcohol, tabacco or any habit-forming drug? NO___ YES___

2. Are you now under observation or taking treatment? NO___ YES___

3. Do you smoke? NO___ YES___

4. Other than above, have you:

a. Had any physical disorder or any known indication thereof? NO___ YES___

b. Had a medical examination, consultations, illness, injury, surgery? NO___ YES___

c. Been a patient in a hospital, clinic, sanitarium, or other medical facility? NO___ YES___

d. Had electrocardiogram, x-ray or other diagnostic test? NO___ YES___

5. Have you ever had military service deferment, rejection or discharge because of physical or mental condition? NO___ YES___

6. Have you ever applied for or receive a pension, payment, or benefit due to injury, sickness or disability? NO___ YES___

7. Have you a parent, brother, sister who died of or had high blood pressure, tuberculosis, diabetes, cancer, heart or kidney disease, or mental illness? NO___ YES___

8. FOR FEMALES ONLY:

a. Fave you ever had any abnormal menstruation, prenancy, childbirth or disorder of the female organs or breast? NO___ YES___

b. Are you now pregnant? NO___ YES___

c. Are you taking contraceptive pills? NO___ YES___

9. Have you ever been rejected or terminated for medical insurance including KAISER program, or have been offered insurance at a higher (rated-up) premium? NO___ YES___

I declare that the statements and answers contained herein are full, complete and true, and if found otherwise, I agree that the Health Care agreement may be invalidated. I hereby authorize any person or entity having a record or knowledge of my health to give to Kaiser all information relative to hospitalization, medical treatment or consultation that I may have undergone.

I agree that no binding agreement is created by the mere signing of this application until it is accepted and approved by Kaiser International Healthgroup Inc, containing the Contract Provisions signed by the duly authorize officials of Kaiser International Healthgroup , Inc., is issued to me.

IN WITNESS THEREOF, I have signed this Application this _____ day of _____, 20 _____ in _____ (city / province where Applicant purchased the Kaiser Plan)

_____
Signature of Applicant

_____
Printed Name

_____
Signature of Sales Counselor

_____
Printed Name

_____
Counselor's Code

_____
Signature of Sales Counselor

_____
Printed Name

_____
Counselor's Code

_____
Name of Marketing Director / Sales Manager & Code