COOPERATIVE HEALTH MANAGEMENT FEDERATION

Unit 102 Malakas Suite, #88 Malakas St., Brgy. Pinyahan, Central District, Diliman, Quezon City
Tel. No. 02-89310387 / 02-82832321Email: 1coophealth@chmf.coop

ID REPLACEMENT REQUEST FORM

(IMPORTANT: Kindly fill-up this form and attach the required documents)

Date Submitted: _____

PATIENT'S NAME: _____
(Surname) **(First Name)** (Middle Name) (Ext.)

POLICY NUMBER: _____

COOPERATIVE NAME: _____

CONTACT NUMBER: _____

EMAIL ADDRESS: _____

ID REPLACEMENT REQUIREMENTS CHECKLIST

(To be filled up by the COOP Representative or COOP Member)

Please check the box to the corresponding documents submitted and reason of ID replacement.

DAMAGE / CANNOT BE READ
- ☐ Completely filled-up ID Replacement request form
- ☐ Photocopy of Valid ID
- ☐ Return damage Card

CHANGE OF SURNAME IF MARRIED
- ☐ Completely filled-up ID Replacement request form
- ☐ Photocopy of Marriage Certificate
- ☐ Photocopy of Valid ID
- ☐ Return old Card

UPGRADING OF PLAN
- ☐ Completely filled-up ID Replacement request form
- ☐ Photocopy of Valid ID
- ☐ Return old Card

INCORRECT SPELLING OF NAMES
- ☐ Completely filled-up ID Replacement request form
- ☐ Photocopy of Valid ID
- ☐ Php 200.00 fee for the replacement

CARD LOST
- ☐ Completely filled-up ID Replacement request form
- ☐ Affidavit of Loss (Notarized)
- ☐ Photocopy of Valid ID

  Php 200.00 fee for the replacement

NOTE:

1. Incomplete requirements will not be processed.

For inquiries, questions and concerns, you may contact the **Membership Department** thru Mobile: 0977-8291760 / Landline: 02-82832321 or thru email: ict@chmf.coop

Submitted by:	**Checked by:**	**Received by:**
(Signature over printed name)	**(Signature over printed name)**	**(Signature over printed name)**
Member	*Cooperative In-charge*	*CHMF Staff*