



Republic of the Philippines  
**Department of Education**  
REGION VIII  
SCHOOLS DIVISION OF BILIRAN

February 11, 2026

**DIVISION MEMORANDUM**

No. 074 s. 2026

**IMPLEMENTATION OF FY 2026 MEDICAL ALLOWANCE**

TO: OIC-Asst. Schools Division Superintendent  
Chief Education Supervisors  
Division Office Personnel  
Public School District Supervisors  
Public Elementary and Secondary School Heads  
All Others Concerned

1. Pursuant to DepEd Order No. 16, s. 2025, titled "Guidelines on the Grant of Medical Allowance to the Department of Education Personnel", and in accordance with Executive Order No. 64, s. 2024 and DBM Circular No. 2024-6, this Office shall implement the release of the Medical Allowance amounting to ₱7,000.00 to eligible personnel for Fiscal Year 2026.

2. Based on guidelines, there are two (2) modes of availment namely:

1. Group Availment (Agency-procured HMO)
2. Individual Availment

Option 1: Payroll Disbursement for availment of new/renewal of HMO

Option 2: Cash form for payment of medical expenses.

3. All eligible personnel are required to submit the Annex A - Medical Allowance Registration Form by School to the District Office.

4. The District Office shall check the accuracy and completeness of the information in the forms before submission to the Division Office Records Section **on or before February 20, 2026**.

5. The Administrative Unit-Personnel Section shall consolidate the forms and prepare the payroll for those who opted for individual availment.

6. Those 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. This refers to those who will retire, resign, transfer or on leave within FY 2026.



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7. Newly-hired personnel shall be eligible to receive the Medical allowance only after rendering six (6) months of service.

8. Those who will opt for group availment will be done thru a regular procurement process while individual availment shall be on a cash advance or reimbursement basis.

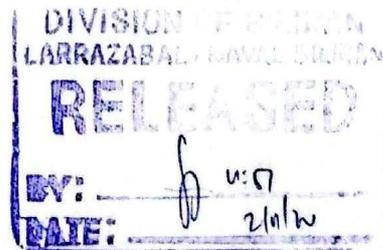
9. Wide dissemination of and strict compliance of this Memorandum are desired.



**ROBERTO N. MANGALIMAN PhD, CESO VI**  
Schools Division Superintendent

Enclosures:

- Annex A template
- Annex B template



**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

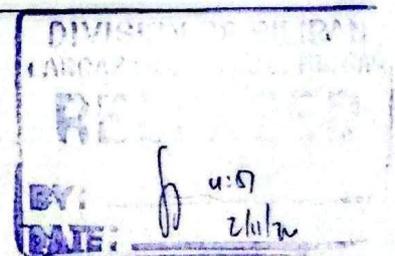
Individual

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

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



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**Section 1: Employee Information**

Full Name: \_\_\_\_\_  
Employee ID Number: \_\_\_\_\_ Position/ Designation: \_\_\_\_\_  
Office: \_\_\_\_\_  
Service Duration: (From — To): \_\_\_\_\_  
Sex: \_\_\_\_\_ Date of Birth (dd/mm/yyyy): \_\_\_\_\_  
Mobile Number: \_\_\_\_\_  
DepEd Email Address: \_\_\_\_\_  
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

