Extending Social Protection through Health Micro-Insurance Schemes to Women in the Informal Economy

(RAS/01/02/MNOR)

Module 3

Reference Guide and Tools on Health Micro-Insurance Schemes in the Philippines

The Organization and Administrative Management of a Health Micro-Insurance Scheme

STEP Strategies & Tools against Social Exclusion & Poverty

International Labour Organization
Subregional Office for
South East Asia and the Pacific

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Purpose

Chapter 3 aims to provide you with a guide in organizing and running your HMIS. It covers the organizational structure and linkages of entities involved in your HMIS and the necessary administrative functions that must be undertaken. It is hoped that after going through this chapter, you will be equipped with the necessary information on the organizational arrangements and administrative systems considered most critical in running an efficient and effective scheme. Hopefully, you will be able to translate and apply these in running your respective HMIS.

Content

In this chapter, you will be introduced to the importance of management systems in your HMIS. First, it outlines the organizational structures that you need to set-up to govern your HMIS together with the corresponding roles and responsibilities. It will also provide you with details on the by-laws as well as policies, systems and procedures (PSPs) that guide your operations. Secondly, you will be oriented on the administrative arrangements that your HMIS must undertake. In particular, these include the enrolment of your members, the registry of their contributions, the mechanism in collecting their premiums and approaches in providing the services.

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3.1.1 Importance of Establishing HMIS Management System

Health micro-insurance schemes in the Philippines are established primarily to make quality health care more accessible to those of you in the informal economy until such time that the National Health Insurance Program being managed by PhilHealth could integrate these community risk-pooling schemes. Though HMIS are established with a social objective and are rooted to the principles of mutual aid and solidarity, they are not exempted from other organization required to provide services of high quality and to operate effectively. HMIS, like yours, are built and maintained through the hard-earned contributions of each of your members. It is important therefore that your HMIS operations are properly managed and your resources utilized rationally to fully benefit your members. The management of your own HMIS largely determines the success of its activities and the achievement of its objectives.

(a) Building Confidence: For one, good management boosts your members' confidence. This is particularly important if your HMIS requires your members to pay regular contributions without receiving any immediate benefit. Remember that your members benefit from the contributions they pay, only when a contingency occurs, that is, often several months after they have begun to pay contributions. They must have confidence in your HMIS that it is able to help them when they are in need.

Effective management also boosts the confidence of your health care providers towards your HMIS. They need to be reassured that your HMIS will always be in a position to pay the invoices for care they dispensed to your members.

(b) Viability of the Scheme: Note that your HMIS is an insurance system against a " sickness risk," which is relatively complex to manage. It is compounded by its very nature of uncertainty due to this risk. It is imperative that your scheme remains viable. This means that you need to put in place management systems of forecasting and accounting and financial control to counter any possibility of adverse events and maintain the viability of your HMIS against such diverse situations.

(c) Minimize Dysfunctions: The type of management system you will establish is vital to the operations of your HMIS. It is important that you define this management system at the very beginning - the same time when you are defining your HMIS' organizational structure and operational arrangements. Experience has shown that if the management system is not well defined prior to the initiation of activities, your HMIS is very likely to experience major dysfunctions that lead to uncontrollable operational issues and concerns. Ultimately, it will result to an irreversible loss of credibility in the eyes of your potential members and service providers.

You are provided in this Module simple and effective management guide and tools in managing your respective HMIS. In particular, Module 3 discusses the organization and operation of your HMIS and provides guides and tools on administrative management. Module 4 deals more with the accounting and financial management of your HMIS. Note that the documents presented here are only examples to optimize your understanding. They do not pretend to meet all your management needs.

3.1.2 Various Aspects of HMIS Management

Managing an HMIS involves mobilizing and using as effectively as possible a series of resources to carry out activities intended to meet its objectives. Any organization like your HMIS has three types of resources to mobilize and manage. These include: (a) human resources, (b) material resources, and (c) financial resources.

(a) *Human Resource*: Human resources are frequently the most valuable resource but also the most complex to manage. Your management involves very diverse aspects, but resides first and foremost on motivating your individual staff or volunteers. The available human resources in your HMIS depend largely on the size of your organization and the amount of contributions that you ask your members to pay.

If your HMIS has few members, the operation of your HMIS may reside primarily on voluntary work, notwithstanding the fact that administrative and management functions are often demanding and time consuming. In this case, your HMIS must encourage volunteers, distribute the tasks and responsibilities and set up simple administrative and financial procedures. It must also offer opportunities for self-development and learning to be truly motivating. If your HMIS has large membership, you entrust a substantial proportion of your activities to paid staff. You must therefore establish an adequate recruitment, hiring, management and assessment procedures of your staff.

(b) *Material Resources:* Unlike a production enterprise which must purchase necessary machines and instruments, your HMIS does not require a lot of equipment to operate. Since it is a service enterprise, it would primarily manage financial flows and information flows. You must have therefore the appropriate resources to carry out this function. Equipment may be necessary if you establish your own clinics or centers to provide the health services to your members.

(c) *Financial Resources*: If you want your HMIS to be operational and financially viable, you must set in place management tools and procedures. You should also allocate functions to the different bodies you have created. These management tools should encompass the effective collection of your members' contributions, safe-keeping of your funds, forecasting of your income and expenditure, keeping your management documents up to date, monitoring and regularly analyzing the invoices you received, the expenditures you incurred and the overall financial status of your HMIS.

There are basically three areas which you need to focus on in managing your HMIS. These are:

- **Organization and Operation:** This area of management is determined by the organizational structures that you set-up and the By-Laws as well as the Policies, Systems and Procedures (PSPs) that you establish, the meetings your organization undertakes and the relationship you have with your service providers or external partners.
- **Administrative Management:** Administrative management involves your tasks on membership registration and monitoring, collection of contributions, their entry on the books as well as monitoring and payment or benefits. These tasks are particularly important because contributions and benefits are the main source of income and expenditure of your HMIS. The tools used for administrative management also make it possible for you to have all the information necessary to carry out monitoring and analysis of your overall HMIS performance.
- **Accounting and Financial Management:** The purpose of accounting management is to record the various transactions of your HMIS in the form of inflows and outflows of resources, and to file and process them. Accounting management follows the different stages of your HMIS activities in a given period (usually 1 year), known as a financial year (start-up, operation and closure). The purpose of financial management is to ensure long-term financial viability of your HMIS. It aims to forecast and control your revenue and expenditure, analyze your financial situation and manage your financial

investments.

Your accomplishment of the above documents are expected to give you information in keeping track the progress of your HMIS operations, and as basis for developing your monitoring tools themselves. Monitoring of your HMIS is the focus of discussion in the Module 5.

3.1.3 Main Management Aids and Tools

There are various tools and records that will help you set-up the management system in your HMIS. These are summarized as follows. Note that the details of each are described in the subsequent sections of this module and in Module 4.

- **Administrative Management:**
  - The Membership Card
  - The Register of Members
  - The Certificate of Entitlement
  - The Invoice
- **Accounting Management:**
  - The Cash Journal
  - The Cash-in-Bank Journal
  - The Cash Receipt Book
  - The Cash Disbursement Book
  - The Petty Cash Form
  - The General Ledger
  - The Statement of Income and Expenditure
  - The Balance Sheet
- **Financial Management**
  - The Action Plan
  - The Budget
  - The Cash Flow Forecast
  - The Statement of Income and Expenditure
  - The Balance Sheet
  - The Financial Ratios Record

This section concerns the organization and operation of your HMIS. It deals first with the management structures to be set up and the By-Laws as well as Policies, Systems and Procedures (PSPs) to be established. While the structural bodies to be formed have been introduced briefly in Module 1, there is a need to know their expected responsibilities and understand how they link-up with one another. In addition, the By-Laws that govern theoperations of your HMIS are presented together with the PSPs. The minutes of meetings as a vital tool in managing the operations of your HMIS is also presented and discussed. Lastly, the section summarizes the different external partners your HMIS may have to deal with and therefore, it gave you some options to consider in granting benefits. Lastly, it looks into the Memorandum of Agreement (MOA) you may enter into with your potential external partners.

3.2.1 The Management Structures

The type of management structure is a very important aspect in the operation of your HMIS. You must think about this management structure up-front, specifically during the stage when you are defining the organization and operation of your HMIS. You must have a precise definition of the authorities and responsibilities of your management bodies to ensure that your HMIS function effectively. Your organizational chart must precisely determine the place of each structure/unit and define each of their functions and responsibilities and attribute their corresponding authority.

The HMIS may consist of the following management bodies:

- General Assembly
- Board of Directors
- Executive Body
- Auditing Body

Most of the cooperatives running HMIS in the Philippines usually require only two management bodies, the General Assembly and the Board of Directors. In more complex or advanced associations or groups, an Executive Body is also formed, and in some instances, these are composed of salaried staff. Other committees may also be formed depending on the size and complexity of the needs and activities of your HMIS:

- Medical Committee
- Committee of Experts
- Monitoring and Evaluation Committee (in some cases, this function is merged with the Auditing Body)
- Grievance Committee

This Guide deals with the management bodies found in most HMIS in the Philippines, namely: the General Assembly (GA), the Board of Directors (BD), the Executive Body (EB) and the Auditing Body.

(a) The General Assembly (GA)

(a.1) Overall Function: The General Assembly (GA) is the most important and highest decision-making body in your HMIS. It determines your By-Laws, its decisions bind all its members and all the other management units. During the first General Assembly meeting or the so-called formal launching of your HMIS, your members determine and establish the By-Laws as well as the PSPs of your HMIS.

(a.2)Frequency of Meeting: The GA is normally convened at least once a year to approve the annual accounts and budget. In most cases, it also convenes upon the request of at least one fifth of the members of your HMIS. This is called the Special General Assembly. According to

the By-Laws or the PSPs, the GA may also be convened at the request of the Board of Directors, the Executive Body or even the Auditing Body.

(a.3) Duties and Responsibilities:

- define the mission of the HMIS and formulate its By-Laws
- approve and alter the By-Laws
- examine and approve the activity reports of the various bodies, including the Auditing Body
- examine and approve the annual accounts and budget
- establish the amount of contributions and any special contributions
- elect the members of the Board of Directors
- elect the members of the Auditing Body
- define the new directions of the HMIS
- decide on mergers with another HMIS, or wind-up the HMIS
- decide on the admission or exclusion of members of the scheme (more common in small health micro-insurance schemes or those with annual contributions)
- decide on any other matters provided for by the By-Laws
- decide on the benefits offered by the HMIS

As far as adjustments in contributions are concerned, the GA may delegate its powers to the Board of Directors for a definite period - often one year, renewable after approving the decisions taken the previous year. This allows decisions to be taken rapidly if the financial situation makes it necessary, like for example, the changes in the cost of medicines or inflation).

(b) The Board of Directors (BD)

(b.1) Overall Function: The Board of Directors (BD) is the body responsible for managing the HMIS. It exercises all the responsibilities not specifically entrusted by law or the HMIS By-Laws to the GA or the Auditing Body. The members of the BD are all volunteers who agree to make their skills and part of their time available to others.

The BD asks the GA to consider its decisions to admit and exclude members. Once these decisions have been adopted, these are enforced by the BD. While awaiting the GA's decision on such proposals, members may be provisionally admitted or suspended. This may be difficult to apply in large-scale HMIS. It is possible though to delegate responsibility for admitting or excluding members to the BD or the Executive Board. In this case an appeal to another managing body, such as the Auditing Body or the GA itself, is also possible.

(b.2) Delegation of Powers: The BD may delegate part of its powers to the Chairperson or to one or more directors. As far as the daily management and specific implementation of decisions is concerned, the BD may delegate certain powers to the Executive Board.

(b.3) Duties and Responsibilities:

- ensure respect for the By-Laws with a view to attaining the objectives of the HMIS
- propose the admission or expulsion of members and apply the disciplinary penalties provided for, if necessary
- nominate the responsible members of the Executive Body

- draw up the annual accounts and budget for the following financial year
- coordinate the work of the various committees
- draw up the activity reports of the HMIS on an annual basis
- represent the HMIS in its relations with the third parties and establish relations with other associations, particularly other social movements which are also founded on solidarity
- sign agreements/conventions, specially with care providers
- establish staff pay
- recruit the director/manager (if are paid and not elected)
- fulfil all other missions entrusted by the By-Laws or the GA

The BD must permanently monitor the management of the HMIS and address the problems it faces.

(c) The Executive Body (EB)

(c.1) Overall Function: The principal executing body is generally the Executive Body (EB). It is also called the Executive Committee, Management Committee or Management Board. In many HMIS, the management-related functions are ensured by voluntary members of the Executive Board. This involves day-to-day tasks, organizing activities, supplies or the maintenance of premises. The EB is responsible for the day-to-day administration of the HMIS:

(c.2) Duties and Responsibilities:

- prepare budget BD and ensure proper implementation once approved
- present to BD the annual accounts and execute the budget
- make any proposal to BD to achieve HMIS objectives more thoroughly
- negotiate conventions/agreements after submission to BD
- manage the HMIS assets and funds
- recruit/supervise personnel (except the director/manager)
- ensure liaison between members and the management
- negotiate with providers and protect members' health interests
- exercise functions indicated in the By-Laws or endorsed by BD and GA

(c.3) Composition: Above a certain size, an HMIS may become professional and recruit permanent staff. In general, paid staff do not form part of the management bodies but are entrusted with technical and administrative tasks linked to daily management including accounting and office work. The Executive Body is often made up of members of the BD, such as the Chairperson, the Secretary or the Treasurer. The following are the responsibilities of the members of the EB.

Box No. 3.1: Responsibilities of the Executive Board Members	
Titles	**Functions**
Chairperson	• coordinates the HMIS activities • chairs meetings of the Executive Body • leads the team of permanent staff • orders expenditure • fixes the agenda of meetings • co-signs cheques
Secretary	• manages the administration of the HMIS • proposes agenda and draws up minutes of meetings • ensures the HMIS correspondence • keeps and files documents
Asst Secretary	• supports secretary in his or her work
Treasurer	• manages the HMIS funds • keeps accounting records • draws up financial reports • deals with collections • carries out expenditure and co-signs cheque • ensures respect for budgets
Asst. Treasurer	• supports treasurer in his or her work

(d) The Auditing Body (AB)

(d.1) Composition: Elected by the GA, the Auditing Body (AB) verifies the implementation of the GA's decisions, proposes improvements and guarantees that the HMIS management bodies function efficiently. Even in relatively small or recently created HMIS, it is essential to designate a person who, after appropriate training, will closely examine receipts and accounting records. This requires special skills and cannot be carried out by the GA. Sometimes this Auditing Body is also tasked to do the monitoring and evaluation, hence they become the Monitoring Committee.

(d.2) Duties and Responsibilities:

- ensure that minutes of the management bodies conform to the By-Laws as well as the PSPs and do not contravene laws and regulations in force in the country
- control the accuracy of the accounts and regularity of financial transactions
- control the execution of decisions of the GA
- draw the attention of the responsible management bodies to irregularities committed and propose measures or procedures to avoid repetition
- ensure respect for the HMIS By Laws and PSPs
- receive complaints from members concerning the services offered and ask the competent body/person to correct them;
- require the competent person or body to carry out a task which has not been performed or which has been poorly performed, and ask for necessary procedures to be applied

- examine and check the conditions of eligibility of members taking part in the GA
- exercise all the functions assigned to it by the By-Laws and the PSPs

3.2.2 The By-Laws and Policies, Systems and Procedures

The documents concerning organization and internal operation of your HMIS define the framework for its management and lists down the responsibilities of each player, specifically who does what and how. At the start, these documents need not be that rigid. They need to be reviewed and adjusted regularly as new situations present themselves. The principal organization and functioning documents include :

- The By-Laws
- The Policies, Systems and Procedures
- The Minutes of Meetings
- The Memorandum of Agreement

3.2.a The By-Laws

a.1 What are the By-Laws for?

The HMIS is incorporated by means of By-Laws. An inaugural or first meeting of the GA officially precedes the creation of the HMIS by providing it with legal personality.

In the Philippines, the operation of the HMIS is regulated according to the needs of the community and is derived from legislative laws on cooperatives and non-profit making associations, mutual savings and credit banks. The rules relating to the objectives and functions of your HMIS are defined by the By-Laws, which determine the rights and duties of the members and the role of the different management bodies. They establish the means, guaranteeing that the HMIS functions democratically and jointly.

a.2 What information does the By-Laws contain?

Despite the lack of regulation, the By-Laws of many HMIS in the Philippines have the same logical structure. This Guide suggests the basic information found in most By-Laws. There are basically five sections of the By-Laws that highlight each set of pertinent information:

Title 1 : The General Provisions

Title II: Administration of the Health Micro- Insurance Scheme: composition, election and powers of the management bodies.

Title III : Financial Provisions

Title IV : Obligations of the Health Micro-Insurance Scheme and its Members (may be specified in the internal rules of procedure)

Title V : Rules of Application, Amendments, Membership of Unions, Federation, Merger, Winding-up and Liquidation

The following outlines in more detail the contents of each section of the By-Laws.

Title I : General Provisions
Chapter 1 : Incorporation and Object of the Health Micro-Insurance Scheme

Article 1 : Incorporation
Article 2 : Object
Article 3 : Field of Action/Prohibitions

Chapter 2 : Conditions of Admission, Withdrawal, Suspension,Deregistration and Exclusion

Section 2.1 : Conditions of Admission
Article 4 : Conditions
Article 5 : Capacity of Member (ordinary/honorary member)
Article 6 : Common Premises
Article 7 : Terms of Membership
Section 2.2 : Conditions of Withdrawal, Suspension, Exclusion, and Deregistration
Article 8 : Withdrawal
Article 9 : Suspension
Article 10 : Exclusion
Article 11 : Deregistration
Article 12 : Special Provisions

Title II : Administration/Functioning of the Health Micro-Insurance Scheme: Composition, Election and Powers of the Management Bodies

Chapter 1 : The General Assembly (GA)
Article 13 : Composition
Article 14 : Election
Article 15 : Powers

Chapter 2 : The Board of Directors (BD)
Article 16 : Composition
Article 17 : Election
Article 18 : Powers

Chapter 3 : The Auditing Body (AB)
Article 19 : Composition
Article 20 : Election
Article 21 : Powers

Chapter 4 : The Executive Body (EB)
Article 22 : Composition
Article 23 : Election
Article 24 : Powers

Title III : Financial Provisions
Chapter 1 : Revenue and Expenditure
Article 25 : The Revenue of the Health Micro-Insurance Scheme
Article 26 : The Expenditure of the Health Micro-Insurance Scheme

Chapter 2	**:**	**Methods of Investing and Withdrawing Funds**
Article 27	**:**	**Legal Reserves**
Article 28	:	Methods of Investing
Title IV and its and	**:**	**Obligations of the Health Micro-Insurance Scheme Members (may be specified in the Policies, Systems Procedures)**
Chapter 1	**:**	**Obligations of Members**
Article 29	:	Membership Fees
Article 30	:	Contributions
Article 31	:	Conditions of Access to Benefits
Chapter 2	**:**	**Obligations of the Health Micro-Insurance Scheme**
Article 32	:	Benefits of the Health Micro-Insurance Scheme
Article 33	:	Information on Members
Title V	**:**	**Rules of Application, Amendments, Membership of Unions, Federation Merger, Winding-up and Liquidation**
Chapter 1	**:**	**Rules of application and amendments**
Article 32	:	The Policies, Systems and Procedures
Article 33	:	Amendments and Alterations
Chapter 2	**:**	**Membership of Unions, Merger and Demerger**
Article 34	:	Unions
Article 35	:	Merger
Article 36	:	Demerger
Chapter 3	**:**	**Winding-up and Liquidation**
Article 37	:	Winding-up
Article 38	:	Liquidation

a.3 How are the By-Laws used?

The By-Laws are a collective contract between your HMIS and the members. They are a reference document regarding the following:

- its name and registered office
- the objectives pursued
- the services offered
- the conditions of admission and coverage of dependents
- the methods of establishing contributions
- the methods and procedure regarding the election of members of the Board of Directors
- the rules of operation of the health micro-insurance scheme not provided for by law or other official texts

Table 3.1: Preparation and Use of HMIS's By-Laws

Health Micro-Insurance Scheme Internal Organisation				External Partners	
General Assembly	Executive Body	Board of Directors	Auditing Body	Adm Authorities	Other Partners
(2) Adopts By-Laws	(3) Carries out activities according to terms set down in the By-Laws	(1) Prepares By-Laws (1.a) Prepares simplified version of By-Laws	(4.a) Controls monitoring and respect for By-Laws	(4.b) Checks conformity with regulations and recording	(4.c) May consult By-laws

The above table summarizes the different responsibilities of those involved in relation to the By-Laws.

(1) The By-Laws are generally drafted by the Executive Body or the Board of Directors.
(2) The General Assembly is responsible for approving them.
(3) When the By-Laws have been adopted the Executive Body administers the activities according to the methods described.
(4) Given the rather inaccessible nature of the regulatory texts supplied to members during the first GA meeting, a simplified version of the By-laws adapted to their level of understanding may be necessary to improve transparency and participative democracy in your HMIS.
(5) Only the GA may alter the provisions laid down in the By-Laws. The By-Laws will be sent to the administrative authorities to be recorded, in accordance with the regulations in force.

a.4 Example of By-Laws: Please refer to Annex 3.1 for the actual sample of the HMIS' By-Laws.

Document 3.2.2.b: The Policies, Systems and Procedures

b.1 What are the Policies, Systems and Procedures for?

Provisions concerning the practical operation of your HMIS but not articulated in the By-

Laws are defined in the Policies, Systems and Procedures (PSPs). These are usually practical methods such as:

- documents for members contributing for the first time
- the content of membership records
- the conditions required to be considered a beneficiary or dependent
- the amount and details of membership fees and contributions
- the detailed functioning of structures
- conditions of access to the benefits detailed

b.2 What information does the Policies, Systems and Procedures Contain?

The PSPs complete and clarify the By-Laws of your HMIS. They therefore require the same information as the By-Laws:

Title I	**:**	**General Provisions**
Chapter 1	:	Incorporation and Object of the Health Micro-Insurance Scheme
Chapter 2 and	:	Conditions of Admission, Withdrawal, Suspension, Deregistration Exclusion
Title II	**:**	**Administration/Functioning of the Health Micro-Insurance Scheme: Composition, Election and Powers of the Management Bodies**
Chapter 1	:	The General Assembly (GA)
Chapter 2	:	The Board of Directors (BD)
Chapter 3	:	The Auditing Body (AB)
Chapter 4	:	The Executive Body (EB)
Title III	**:**	**Financial Provisions**
Title IV	**:**	**Obligations of the Health Insurance Scheme and Its Members**
Chapter 1	:	Obligations of Members
Chapter 2	:	Obligations of the Health Micro-Insurance Scheme
Title V	**:**	**Rules of Application, Amendments, Membership of Unions, Federation, Merger, Winding-up and Liquidation**
Chapter 1	:	Rules of Application and Amendments
Chapter 2	:	Membership of Unions, Merger and Demerger
Chapter 3	:	Winding-up and Liquidation

b.3 How are the Policies, Systems and Procedures used?

All members must comply with the PSPs in the same way as the By-Laws.

Table 3.2: Preparation and Use of the Policies, Systems and Procedures

Health Micro-Insurance Scheme Internal Organisation				External Partners	
General Assembly	**Executive Body**	**Board of Directors**	**Auditing Body**	**Admin. Authorities**	**Other Partners**
		(1) Prepares PSPs and may alter them			
(2) Adopts or ratifies PSPs					
	(3) Executes activities according to terms indicated in the PSPs	(1a) Prepares simplified version of PSPs	(4a) Controls monitoring and respect for PSPs	(4b) Verifies conformity with regulations and recording	(4c) May consult PSPs

Table 3.2 summarises the responsibilities of those involved in preparing the organization and functioning documents.

(1) the PSPs are generally prepared by the Executive Body or the Board of Directors.

(2) the GA is responsible for approving the PSPs.

(3) once these are approved during the first meeting of the GA, the PSPs constitute a collective contract between the HMIS and its members. The scope of the PSPs is defined by the By-Laws.

(4) in general, the By-Laws show that the Board of Directors is entitled to make immediately enforceable alterations to the PSPs. The GA may then ratify such alterations.

(5) the Executive Body administers the activities according to the methods described in the PSPs. Like the By-Laws, they will be used as a reference document for the health micro-insurance scheme and can be adapted to the education level and communication

tradition of its members.

(6) A copy of the PSPs, together with the By-Laws, will be sent to the administrative authorities to be recorded, in accordance with the regulations in force.

b.4 Example of Policies, Systems and Procedures: Please refer to Annex 3.2 for the actual example of PSPs.

Document 3.2.2.c: The Minutes of Meetings

c.1 What are the Minutes of Meetings for?

The Minutes of Meetings are important documents for the strategic management of your HMIS. They record the decisions you have taken during your management meetings and in your interaction with external partners. Minutes are recorded for meetings of the General Assembly, Board of Directors or the Executive Body. They constitute the history of the collective decisions of your HMIS.

c.2 What information do the Minutes of Meetings contain?

The Minutes of Meetings usually contain the following:

- date of meeting
- place or venue of meeting
- body convening (General Assembly, Executive Body, Board of
- Directors, Auditing Body)
- agenda
- excused absentees
- absentees not excused
- decisions taken
- end of meeting (time)
- signature of the chairperson and secretary of sessions

This Guide presents an example of Minutes of Meeting which contains the principal information to be recorded during a meeting and the attendance list, possibly with the signatures of those present.

c.3 How are the Minutes of Meetings used?

The Minutes are drafted by the secretary of the session (also called the 'rapporteur'). After each meeting, the body or committee draws up the minutes, including the information indicated above. The minutes are submitted to the members for approval at the following meeting.

Table 3.3: Preparation and Use of the Minutes of Meetings

The minutes make it possible to ensure respect for decisions taken and can be used as evidence in the event of litigation and for justification that meetings have been properly held. The secretary of the health micro-insurance scheme files the minutes according to the date or characteristics of the meeting.

The example presented is adapted for internal meetings (BD, EB, GA, AB). If, on the other hand, it is a meeting with external partners, it is important for the institutions and persons present to be mentioned.

c.4 Example of Minutes of Meeting: Please refer to Annex 3.3 for the format of a Minutes of Meetings.

Table 3.3: Preparation and Use of the Minutes of Meetings

Health Micro-Insurance Scheme Internal Organisation				External Partners	
General Assembly	**Executive Body**	**Board of Directors**	**Auditing Body**	**Admin. Authorities**	**Other Partners**
Minutes per General Assembly	Minutes per EB meeting filing of Minutes of other management bodies	Minutes per BD meeting	Minutes per AB meeting		

Section 3.3: Managing Relations with External Partners

3.3.1 External Partners of Your HMIS

The internal management bodies of your HMIS should work with the external relevant actors. These include, among others, the care providers, suppliers of services and equipment, beneficiaries and members, banking, legal and government institutions and supporting structures. Your relations with each one of them is essential for a smooth operations of your HMIS. You must therefore manage those relations very well.

(a) *The care providers* are your special partners in operating your HMIS. This may be the barangay health station (BHS), a barangay health and nutrition post, a Rural Health Unit (RHU) or a health center, an infirmary or a hospital, but also a pharmacy, individual providers such as a doctor or radiologist, or a health transport company. The quality of relations between your beneficiaries and your providers will partly determine the effectiveness of your HMIS. Cooperation between your HMIS and your health service providers is embodied by signing a Memorandum of Agreement (MOA). The HMIS may be supported by a consultant doctor to manage better this relationship.

Communication between members and beneficiaries is important for your HMIS viability. You must engage in transparent management to win and retain the confidence of your members. You must also ensure that your members are satisfied with the quality of the benefits and services offered by your HMIS. Your members though and their dependents, must respect the terms laid down in the By-Laws and the PSPs.

(b) *Legal or Public Authorities*: In the event of disputes, theft, fraud or other matters, your

Box 3.2 Micro-Finance Systems and Health Micro-Insurance Schemes

Experience has shown that HMIS and micro-finance systems can be complementary.

Many **micro-finance systems** have characteristics that foster the success of implementing an HMIS. They are deemed to manage money in a proper way and already have a reflex of results, profitability and viability. The experience of management bodies in the area of financial and administrative management may also benefit the HMIS. More than that, the existence of a legal and organizational framework and channels for promotion, awareness-raising and information favour the natural implementation of an HMIS. Certain micro-finance systems already have a much more integrated view of development and have developed 'education' and 'health' dimensions to their activities. Others have a relief fund for social risks.

In return, the **HMIS** as a health micro-insurance system may establish loyalty and reinforce the social image of the micro-finance system. The HMIS meets a specific need and reinforces responsibility and foresight. It may also reduce the risk of non-repayment or over-indebtedness. Following an epidemic, for example, it may reduce the risk of a massive withdrawal of savings. (*Source: ILO/STEP Africa, 2000, p.37)*. Cooperatives and mutual benefit groups in the Philippines also serve the same purpose. Cooperatives provide a variety of services for their members such as micro-finance or access to credit and social services like health micro-insurance,

HMIS must be supported by these legal or public authorities. In this context, your HMIS should therefore play the role of a legal body. More than that, certain national agencies (with administrative authority) and decentralized services may provide activities or services in favour of your HMIS.

(c) *Financial Structures:* The management of your HMIS is based largely on its financial structures such as savings banks, or savings and credit co-operatives from which your HMIS may secure its funds. Invoices may be paid through bank transfer.

In the Philippines, HMIS have been legislated as part of the programs or services provided by the cooperatives or community-based organizations. You must therefore in all cases, let your HMIS act in compliance with the existing regulations. You may also contact other health micro-insurance schemes, unions or federations. You may also benefit from the backing of support structures at technical, financial or organizational level.

3.3.2 Granting Benefits

Generally, the cost of health services is shared between your beneficiary and your HMIS. A tripartite relationship is established among you, the manager or operator of your HMIS, your beneficiary and your care provider.

Two possibilities must be considered for granting benefits to your beneficiaries. This may involve care delivered by providers who have signed an agreement with your HMIS, or care provided by the facilities which you established yourself. You have two options on how pay the cost of the health care:

Option 1: Indirect Third Party Payment
Either your beneficiary pays the total amount of the services they have used and are reimbursed subsequently by your HMIS

Option 2: Direct Payment Third Party Payment
Your HMIS pays the provider directly.

(a) *Payment of Care by the Beneficiary: Indirect Payment or Third Party Payment*

In this option, you ask your beneficiaries to pay the costs of the services provided before you reimburse them. In this case, your beneficiary pays according to the methods adopted by the care provider (payment at the time, by episode of illness or by outpatient care), and according to the rates you have agreed upon with your service provider.

Your beneficiary will therefore request the care provider you contracted for a proof of payment, usually a receipt or invoice, that must include at least:

- the identification of the care provider
- the identification of the beneficiary
- the nature, cost and date of the benefit

Equipped with his/her Membership Book and proof of payment, the beneficiary goes to your HMIS office to be reimbursed.

The disadvantages of this form of payment for your beneficiary are: they are obliged to have the total amount necessary to pay for the care and, on the other, the need for additional formalities and to wait for reimbursement. The disadvantages of this option for your HMIS are

the additional procedures which imply greater administration costs on your part.

The advantage of this system for your HMIS on the other hand is that it limits over-consumption, a tendency to abuse of the system and fraudulent invoicing.

(b) Direct Payment by the Health Micro-Insurance Scheme (Third Party) Payment

This second option is called the direct (third party) payment because it is not your beneficiary who pays but your HMIS - the third party in addition to the provider and the beneficiary. This option is often adopted for 'major risks' involving substantial costs which your beneficiary cannot meet (e.g. hospitalization or surgery). In certain cases, your beneficiary also pays a patient's contribution to the provider. Your HMIS pays the service provider directly, upon presentation of an invoice.

You may negotiate with the provider and make a deposit available to them. This deposit will assure the care provider of your HMIS ability to pay. After this gesture of confidence, the care provider may issue invoices for care over a longer period and therefore in turn, adopt longer payment times. If this is convenient, you may negotiate with the provider to use the deposit as working capital for supplying stocks of medicines. .

The direct payment system is more advantageous for the beneficiary, since there are no cash problems, no formalities and no waiting for costs to be reimbursed. Administratively, the system may be less costly (reclassification of payments by provider rather than by beneficiary), but there is less potential for controlling the real situation of the care provided, and risks of over-consumption and mounting costs in particular are greater. Different discounts may also be granted, according to whether essential generic or proprietary medicines are involved, so as to favour the use of the former.

Some HMISs combine the two options in carrying out the payment of the cost of health care. According to the nature of the care, you may combine these two methods. For example, you may reimburse your beneficiary for minor expenses (e.g. outpatient care) and pay your care providers directly for more significant expenditures like hospitalization.

There is another scheme which some HMIS used to pay for the health services rendered to the members. This is the "capitation" scheme whereby the HMIS guarantees a fixed amount to the partner service provider (e.g. hospital) every year corresponding to the number of its subscribers or members.

One example of this scheme in the Philippines is the ORT-HPS in San Fernando, La Union. The ORT-HPS partnered with the Ilocos Regional Training and Regional Medical Center to provide health care to its members through a capitation contract. The ORT-HPS pays a yearly fixed income to the hospital depending on the number of its enrolled and qualified members during the year.

This scheme is less cumbersome on the part of the HMIS in terms of paying for health services since they only need to monitor if the members availing the services are qualified or entitled or not in coordination with their partner hospital. The health services are then charged to the capitation fund released earlier to the service provider.

Box 3.3: Services of Health Facilities Established by HMIS

The services of health facilities established by your HMIS may be proposed to members and non-members, with preferential rates for the former. For reasons of sound organization and transparency and in order to be able to evaluate the performance of the different facilities separately, the accounts of your HMIS and the health facilities must always be kept separately, even where non-members will not have access to the services offered.

Health Centers and Hospitals Established by the Scheme:
Several options can be considered:
• the costs of members and their dependents are met 0% once the waiting period has been concluded: they are then provided with care upon presentation of their membership card;
• only the consultation is free of charge, while care and medicines are paid for according to the products used;
• an excess (participation in costs) is accepted by the member for each consultation or act carried out;
• a patient's contribution is established by the HMIS: the patient supports a certain percentage of all the costs of consultations, care and various technical acts.

Pharmaceutical Stores of the HMIS:
The HMIS favours the sale of generic medicines and only delivers proprietary medicines if it is essential. Members will benefit from a preferential rate, while non-members may purchase medicines at the market price.

Source: ILO-STEP/WSM-ANMC, 2000, 'Mutuelles de santé en Afrique: caractéristiques et mise en place. Manuel de formateurs', pages 158-159

3.3.3 Tool for Managing External Relations

Your HMIS relations with its external partners must be very well documented through a memorandum of agreement. Note that the main objective of your HMIS is to provide your beneficiaries with better access to quality health care. Your relationship with care providers will be your cornerstone of better service for your beneficiaries. The establishment of a memorandum of agreement (MOA) between you and the care provider may ensure that this external relationship functions better.

Document 3.3.3a The Memorandum of Agreement

4.a What is the Memorandum of Agreement for?:

The MOA is otherwise known as co-operation agreement. You, being in-charge of your HMIS, sign an agreement with the service or care providers to formalize your partnership and how to operationalize it. Your MOA should establish, among others, the benefits and means of meeting the cost of treatment. It must ensure that your beneficiaries receive quality care at a reasonable pre-established cost.

Your MOA can include: the methods of paying invoices (such as reimbursement, direct payment or indirect payment), the system of granting benefits and the payment of invoices. It consolidates relations with your service provider and is a tool for arbitration in the event of disputes.

The MOA may also include the procedure for meeting costs and the membership procedure for your beneficiaries. These procedures and documents will be discussed in the following sections.

a.2 What information does the Memorandum of Agreement contain ?

The MOA is generally structured as follows:

Preamble: Presentation of the Two Parties
Article 1 : Object: Objective of the Cooperation, Type of Services Covered (must be described as accurately as possible)
Article 2 : Commitments
a. Health Micro-Insurance Scheme
b. Care Provider:Conditions for Meeting Beneficiaries' costs
Article 3 : Duration of the Agreement
Article 4 : Arbitration: Procedure in the Event of Dispute
Article 5 : Revision: Possibility to Alter the Terms of the MOA
Article 6 : Termination: End of the MOA
Signature of the Two Parties
Signature of the Arbitration Authority
Annexes: List of Benefits Offered Plus Costs

a.3 How is the Memorandum of Agreement used?

Table 3.4: Formulation and Signing of the MOA

Health Micro-Insurance Scheme Internal Organisation				External Partners	
General Assembly	**Executive Body**	**Board of Directors**	**Auditing Body**	**Providers**	**Arbitration Authority**
	(1) Examine possibilities and prepare MOA: provisional version	(2) Examine possibilities and prepare MOA: final version			
		(3a) Negotiate and sign MOA	Control/ monitoring of terms set down in MOA	(3b) Negotiate and sign MOA	(3c) Co-sign reference in event of arbitration

Table 3.4 shows the involvement of the different management bodies in the preparation and signing of the MOA.

(1) The EB examines the possibilities for signing MOA with providers including the conditions and possibilities for reductions or demand for a deposit.
(2) The BD then negotiates the terms of the MOA with providers and signs it with the provider in two copies.

The MOA is a reference document and working tool for your HMIS and the care provider. It may also have a legal value, particularly if it bears the stamp of an arbitration authority. The

MOA may be signed by the Chairperson of the Board of Directors of your HMIS or by any other authorized person. The care provider may be bound by the signature of the director, the senior doctor or any other authorized person.
It is important that the provisions contained in your PSPs concerning the conditions for meeting beneficiaries' costs are consistent with the terms of the MOA. In view of the complexity of health-related activities, your MOA may not foresee all potential cases and may leave room for interpretation. In the event of a dispute, your HMIS and the service provider must try to settle their differences amicably. If necessary, the competent authorities will be contacted.
The terms of the MOA may be revised if necessary. The example given in Annex 3.4 describes the partnership and cooperation between a Health Center and the HMIS for meeting the cost of outpatient care, hospitalizations, deliveries and transports.

a.4 Example of a Memorandum of Agreement : Please refer to Annex 3.4 for the actual sample of an HMIS MOA.

For efficient and effective management of your HMIS, you must give particular attention to two administrative concerns in operating your HMIS. These have regard to your members in general and the provision of health services or benefits.

On membership, you need to properly identify them, manage their participation and enrolment by completing and updating your membership registry including their dependents, the collection of their premiums and the recording of these contributions.

On benefits, vital areas to be administered will include the benefit entitlements of your members, their actual availment of services and recording the services provided.

For each of the above operational concerns, there are corresponding administrative documents that could help you manage them well. These documents make it possible for you to record information essential to the administrative management of your HMIS and to the control, monitoring and evaluation of its activities.

These documents present a system of recording pertinent administrative information. Care must be taken at all times to ensure that you and your staff sufficiently understand and master them. However, you need to adapt these documents according to your needs and skills including the characteristics and context of your HMIS.

The principal documents for recording administrative information are:

- For membership:
  - The Membership Book
  - The Register of Beneficiaries
  - The Register of Contributions
- For benefits:
  - The Certificate of Entitlement
  - The invoice
- The Register of Benefits

There are also other supplementary documents such as the contribution deposit slip, the individual or family monitoring form or statements of expenditure of local sections which you can use.

Section 3.4: Administrative Management of a Health Micro-Insurance Scheme

3.4.1 Identifying and Recording Your Membership

After setting up your HMIS or after holding the first GA meeting and at the end of the waiting period, your HMIS must begin to process membership records.

In this regard, you must be able to systematically enlist your members and register the beneficiaries properly . This section examines the key documents useful for processing your new members. These include:

- The Membership Book
- The Register of Beneficiaries

a.1 What is the Membership Book for?

The Membership Book (MB) is an evidence of membership of individuals to your HMIS. Other HMISs call this the Membership Pass Book. Some refer to it as a Membership Card. The Membership Book may take different forms. It may be a family card, in which case it will display all information to precisely identify the member of the family and each of his/her dependents. Other organizations prefer an individual card (one for each beneficiary), while giving priority to family membership. In other HMIS, the Membership Book also serves as a health record. It includes several blank pages for use by health care providers to record their services and prescriptions.

Note that the principal objective of your Membership Book is to identify your members and beneficiaries and to check that their contributions are paid regularly. It shows the logical succession of contributions paid and the benefits used by each of your members.

The MB serves as a "passport" of your members. This confirms to the health care provider that your members are covered by your HMIS. It also helps you check the accuracy of the records on the Register of Contributions and the Register of Beneficiaries at any time. It also serves as a monitoring tool. However, if it is to be effective as such, the MB should bear a photograph of each beneficiary. This however is difficult to achieve given the cost that hampers the poor families from accessing your HMIS. You must bear in mind that there are costs associated in printing the MBs, thus they should be kept as simple as possible. They should not also be renewed too frequently.

a.2 What information does the Membership Book contain?

Your MB should contain the following information:
- Identification of members and their dependents
- Monitoring of contributions

The MB may also include a brief description of your PSPs on:
- methods of meeting costs
- benefits covered/not covered
- illustrations or flowchart to visualise the procedure for meeting costs

For confidentiality reasons, it is not advisable for you to include the diagnosis of medical consultations in your MB. The monitoring of the beneficiaries' medical conditions may be encouraged by using instead a simple reference to any document issued by the service provider. The following information details of an MB are presented below:

Cover Page:

- Details of the HMIS such as address, telephone, etc.
- Logo, if any
- Name of the Member

First Page: identification of member with the following info:

- First name
- Surname
- Sex
- Address
- Telephone Number
- Identity Card Number
- Date of Birth
- Place of Birth
- Beneficiary Code
- Blood Type
- Date of Joining (time of payment of membership fee).

Following Pages: Identification of Dependents

- First Name and Surname
- Identity Card Number
- Connection with Member: relation, under guardianship
- Date and Place of Birth
- Beneficiary Code
- Blood Type
- Photograph
- Date of First contribution

It is advisable that you provide several beneficiary identification pages in order to record new dependents. You may have the photograph replaced by other evidence, such as the fingerprint. You may include the blood type of your member to facilitate medical intervention in the event of an accident.

The summary of the PSPs gives the beneficiaries and providers a better understanding of the methods of meeting costs and fosters transparency of your HMIS to your members, partners and providers including beneficiaries. This helps avoid pointless arguments in the event of disagreement.

Your MB may also show the following among other things:

- the aim of your HMIS
- HMIS structure
- conditions of membership
- conditions of entitlement to benefits

Note that you will be the one to make the final decision regarding the draft, number of pages of your MB and the information it must contain. Remember that the MB can be used as a reference material or a reminder but it also entails cost.

a.3 How is the Membership Book used?

In the By-Laws, the GA stipulates the payment of a membership fee corresponding to the issuance of the MB.

(1) First, you request the applicant to complete the information form. You may request for photographs of his/her beneficiaries. although this is not fully recommended, it may represent a substantial burden to your members. You may, for example, accept that the photograph is not obligatory, provided that the beneficiary furnishes you with an identification card with photograph. Since these are references, in the event of a check, you may have therefore to refer to the identity card.

(2) You attribute a code to each beneficiary, in the knowledge that the member is both a member and a beneficiary. The code may be constructed as follows:

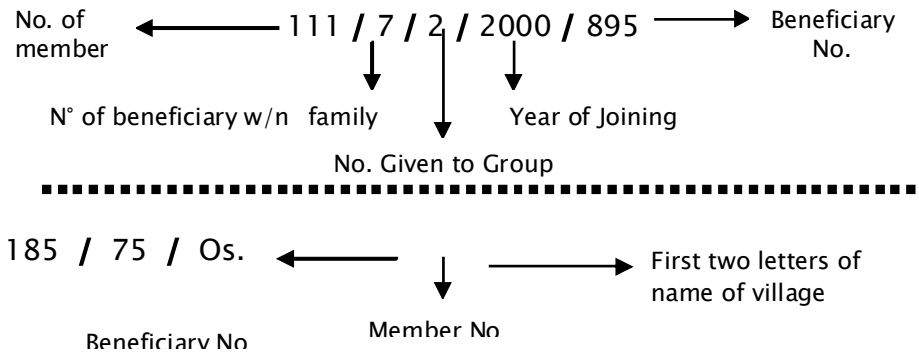
(3) After each contribution is paid, the person responsible for collecting contributions puts a stamp or signature on the space provided in the MB and indicates the total amount of contributions paid. This helps your:

- members to check if their contributions are up-to-date
- care providers to know whether the person concerned meets your HMIS conditions for meeting the cost, together with the certificate of entitlement
- HMIS to have a means of control (comparison with register of contributions - membership book, see following page).

The monitoring of contributions also makes it possible - after joining to keep track of your beneficiary's waiting period.

Box 3.4 Examples of Coding of Beneficiaries

Member:



a.4 Example of Membership Book: Please refer to Annex 3.5 for the actual sample of an HMIS Membership Book.

Document 3.4.1b: The Register of Beneficiaries

b.1 What is the Register of Beneficiaries for?

The Register of Beneficiaries is an important administrative management tool. It is designed to allow you ascertain the following on a regular basis:

- the number of beneficiaries (members and dependents)

- new memberships and withdrawals during an accounting period
- payments of membership fees and contributions,
- renewal of contributions in order to be able to track, from one accounting to the next, the growth in number of members and, where relevant, of cancellations of membership

The Register of Beneficiaries enables your HMIS to record information relating to your beneficiaries and makes it possible for you to monitor the number of beneficiaries of your HMIS at all times, particularly your members and their dependents.

This register also serves to record any changes within a member's family (birth, death, etc). Lastly, it is intended to reflect payment of contributions and identify any arrears.

b.2 What information does the Register of Beneficiaries contain?

The Register of Beneficiaries makes it possible for you to record the following data:

- beneficiary code: indicating the number of the beneficiary and their status (member or simple beneficiary)
- surname and first name
- sex
- address
- date of birth
- status: member or dependant
- date of joining: first contribution
- date of leaving
- comments: reasons for leaving, other relevant information

b.3 How is the Register of Beneficiaries used?

You must record any beneficiary into the Register of Beneficiaries for whom a contribution is paid to your HMIS. You must also assign them with a beneficiary code.

You can use the Register of Beneficiaries at any time to find information on your beneficiaries. You can also find the details of all your members. For example, those who attended the GA.

It can also be used for:

- monitoring the number of members/beneficiaries by means of the coding system
- assessing reasons for leaving your HMIS: for example, members who have not paid their contributions for the last six months
- identifying the number of men/women members of your HMIS, their age group, their location (e.g. if they are near the care provider)

The admission procedure is as follows:

(1) The person goes to your HMIS office and gets information on the conditions of membership and pays for membership.

(2) The Executive Body examines the application and accepts the money, records the membership with a reference in the Register of Beneficiaries to the name of the people whose costs will be met, and completes the membership book with the details of the member and the other beneficiaries.

(3) In the event of doubt as regards acceptance or rejection of the application for admission, the

Table 3.5: The Recording of Members

Health Micro-Insurance Scheme Internal Organisation				External Partners	
Member	**Executive Body**	**Board of Directors**	**Auditing Body**	**Providers**	**Bank**
(1) Demand and pay membership fees	(2) Record new members: update Register of Beneficiaries	(3) Accept or refuse applications to join			
(5) Receive MB	(4) Prepare MB		Control		(7) Collection and recording in HMIS account
	(6) Pay money into bank account				

EB may ask for guidance from the BD.

b.4 Example of a Register of Beneficiaries: Please refer to Annex 3.6 for the actual sample of an HMIS Register of Beneficiaries.

3.4.2 Collection and Recording of Contributions

Another aspect that you need to manage properly regarding your members is the regular collection of their contributions. You must be able to set up a mechanism that enables you to collect and record appropriately these contributions. Note that one of the weaknesses in an HMIS is the difficulty of collecting premiums on a regular basis.

Various reasons have been cited on this regard. For one, your HMIS office or collection center may be located far from your members' area of residence, which could discourage them from going to your office frequently given the extra transport cost. Secondly, with low income and seasonality of their earning, your members are unable to put up the amount of premiums in a lump sum or on quarterly basis so as to reduce the frequency of payments. Thirdly, gender dynamics at the household level oftentimes lead to conflict in allocation of financial resources (e.g., spending on vices such as gambling and alcohol versus investments on health), thus leading to defaults in contributions. On the other hand, small-sized HMIS have no dedicated staff to make these collections. It is critical therefore that your HMIS sets up a mechanism to encourage regular collection of premiums from your members.

You may learn from the practices of several HMIS with regard to the collection of their members' contributions.

(1) Accountability and Collection by Peers: The Mangloy, MPC -Tagum, Davao Norte in Mindanao has organized their structure in such a way that for every 5 members, there is one assigned

member to collect premiums daily. These daily collections are submitted to the HMIS office base weekly. The peer strategy requires the collector in-charge to remain in the area until all the premiums are collected from the group. The peer strategy also demands that the payment of premium of one is the responsibility of all the 5 members. Hence, peer pressure is employed if there is one who is unable to pay regularly. On the other hand, the peers also became a source of assistance and guidance for the rest , thus building up solidarity among the group and sense of responsibility for one another.

(2) Automatic Deduction: The SAKAHA group's decision to include social protection for health among their groups required the automatic deduction of Php 30.00 from their savings in case an immediate member of the family dies or falls sick. The SAKAHA as a credit organization collects loan payment daily through their organized cell groups and module structures. Included in the loan payment by each member is a contribution for their savings in the amount of Php 50.00. It is from these savings collected daily where the Php 30.00 for health services are automatically withdrawn.

(3) SEA K Project: Another project where the SSS premium was collected as part of the regular collection of loan payment. Since the SSS enrolment is optional to their members, those who opted to pay SSS premiums were incorporated in the regular collection. At this time, the credit organization only charges Php .50 of their each monthly collection for administrative fee, part of which is for transmitting these collections to the SSS.

(4) In ORT-OHPS in La Union, they set up 13 satellites which provide education and health services to their members. It is through these satellites that the contributions of their members are collected. The ORT-OHPS staff in these satellites receive the contributions of the members by issuing provisional receipts to the paying membes. At the end of the week, these collections are remitted to their home office where the official receipts are issued.

Given these various mechanisms of collecting contributions, it is equally important that you record these collections properly and keep track of your member's continuous participation. You must note that your members' contributions are the very source of finances to meet the cost of health care your HMIS provide to your members. It is therefore necessary that they are collected regularly, recorded appropriately and are completely accounted for. For this purpose, the Register of Contributions is one document recommended for your HMIS to establish.

Document 3.4.2.a: The Register of Contributions

a.1 What is the Register of Contributions for?

The Register of Contributions makes it possible for you to monitor the situation of contributions of your members on a daily basis. Its principal function is to show whether the beneficiary is entitled to your HMIS benefits. You may establish a waiting period during which your member regularly pays their contributions without being entitled to use the HMIS services. This waiting period may be for one year, for example, for covering deliveries.

a.2 What information does the Register of Contributions contain ?

The Register of Contributions contains the following information. These information make it possible for you to monitor the payment of your members' contributions:

- member's code: member's beneficiary code-responsible for paying the household's contributions to the HMIS
- surname and first names
- number of beneficiaries: member and dependents
- total amount of monthly contributions
- possible arrears from previous year
- amount of contributions paid: (e.g. by month January, February, March, April, etc.)
- years: 2002, 2003, 2004
- possible end-of-year arrears

a.3 How is the Register of Contributions used?

Your member pays a contribution to your HMIS according to the agreed-upon frequency (monthly, quarterly, yearly) in your By-Laws. After recording the contribution in the Membership Book, you record the amount of the contribution again in the Register of Contributions. When your beneficiary appears, you verify whether his/her contributions are up-to-date before issuing the Certificate of Entitlement. The Register of Contributions allows you to examine the number of beneficiaries who are entitled to your HMIS' benefits.

a.4 Example of Register of Contributions: Please refer to Annex 3.7 for the actual sample of an HMIS' Register of Contributions.

Table 3.6 The Recording of Contributions

Health Micro-Insurance Scheme Internal Organisation				External Partners	
Member	**Executive Body**	**Board of Directors**	**Auditing Body**	**Providers**	**Bank**
(1) Pay contributions →	(2) Verify Membership in the Register of Beneficiaries ↓ (3) Record contributions in register of contributions. Update membership book ↓ (4) Pay money into bank account →		(5) Control →		(5) Collect and record in HMIS account

MODULE 3

3.4.3 Recording of Benefits

The procedure for meeting the cost of health care between your HMIS and your care provider is described in the MOA as discussed earlier. For day-to-day management, you are encouraged to record your HMIS' benefits based on three reference key documents:

- The Certificate of Entitlement
- The Register of Benefits
- the invoice

Document 3.4.3a. The Certificate of Entitlement

a.1 What is the Certificate of Entitlement for?

The Certificate of Entitlement assures your service provider that the contributions of the beneficiary concerned are up-to-date and confirms that their costs will be met according to the terms defined in the MOA between you and your service provider.

The use of the Certificate of Entitlement should be considered according to the size of your HMIS, the level of care (cost and frequency) you provide and the level of management. In some cases though, the Certificate of Entitlement may no longer be useful if there is a significant social control among the beneficiaries of your HMIS. If and when you use a Certificate of Entitlement, it is advisable that involve your care provider in preparing the format.

a.2 What information does the Certificate of Entitlement contain?

The Certificate of Entitlement is composed of three parts:

ä Beneficiary Profile Section: This part contains the particulars on the beneficiary.

- member's name
- member's code
- beneficiary name
- beneficiary code
- address
- sex
- date of application

ä Guarantee Section: This part, which contains the following information, is referred to by the service provider before administering the service. This indicates that your HMIS is guaranteeing the payment of the cost of services to be provided to your beneficiaries.

- number of certificate of entitlement
- beneficiary code number
- beneficiary name
- name of provider
- application to meet the cost
- signature of a person in charge of your HMIS
- with a reference to the date

ä Certificate of Care Section: This part, which contains the following information, is detached

by the service provider upon providing care or treatment and send it to your HMIS.

- number of certificate of entitlement
- beneficiary name
- beneficiary code number
- type of benefits
- certificate of care form
- amount paid by the beneficiary and HMIS
- date and signature of provider

a.3 How is the Certificate of Entitlement used?

The proposed Certificate of Entitlement has several functions. When your members fall ill, you draft and issue a Certificate of Entitlement to that particular member. Before issuing this certificate, you keep the Beneficiary Profile which serves as your key reference.

The sick member use the Guarantee and Service Provider Certificate sections of the Certificate of Entitlement and present these to the service provider whom you have contracted to provide

Table 3.7: The Recording of Benefits

Health Micro-Insurance Scheme Internal Organisation				External Partners	
Beneficiary	**Executive Body**	**Board of Directors**	**Auditing Body**	**Providers**	**Bank**
(1) Apply to meet the cost	(2) Verify whether member's contributions are up-to-date				
	(3) Draft certificate of entitlement			(5) Receive member and provide care	
(4b) Receive certificate of entitlement and visit to provider with certificate of entitlement and MB	(4a) File Beneficiary Profile Section of the certificate of entitlement			(6) receive payment of patient's contribution from the beneficiary	
				(7) File Guarantee Section and forward Certificate of Care with invoice to HMIS	
	(8) Check Beneficiary Profile Section, Certificate of Care and receipts				
	(9) Pay service provider	Monitor benefits	Control		(10) Release money

the service. The Guarantee Section acts as confirmation (a guarantee) by your HMIS that the beneficiary's costs will be met by your HMIS according to the conditions provided for in the MOA. The Certificate of Care Section certifies that care has been provided. This is detached and filled-in by your provider and returned with the invoice to your HMIS.

To account for emergencies (e.g. transport during the night, for example), you may recommend the possibility of presenting the Certificate of Entitlement within 24 hours of the first aid as part of your agreement with the provider. The quality and correct use of this Certificate of Entitlement influences the quality of cooperation between you and your care providers. The management of the Certificate of Entitlement in meeting the beneficiary's costs is summarized in the following table.

Table 3.7 outlines the processing and use of the Certificate of Entitlement:

(1) When your beneficiary falls ill, he/she goes to your HMIS with his or her Membership Book. Your HMIS checks the MB and the Register of Contributions to confirm that the beneficiary's contributions are up-to-date.

(2) Your HMIS then hands over a Certificate of Entitlement to your member and retains the Beneficiary Profile Section.

(3) After receiving the Certificate of Entitlement, the beneficiary goes to the care provider and presents his/ her MB and the Certificate of Entitlement.

(4) The provider verifies whether it is the same person indicated in the Certificate of Entitlement and may carry out a second check on the Membership Book for his/her contributions. After providing the care, the provider files the Guarantee Section of the Certificate of Entitlement and sends the Certificate of Care Section with the invoice to the HMIS.

(5) Your HMIS manager in turn compares the Beneficiary Profile Section with the Certificate of Care Section and verifies whether the cost of the benefits invoiced are met by your HMIS. The manager then pays the invoice.

In some HMIS, it is possible for a reference person (e.g. medical secretary or consultant doctor) working in the health center to support the procedure for meeting beneficiaries' costs by facilitating the letters of guarantee. He/she may also record the benefits in a Register of Benefits, while respecting the principal of separation of management.

a.4 Example of Certificate of Entitlement: Please refer to Annex 3.8 for the actual sample of an HMIS' Certificate of Entitlement.

Document 3.4.3.b: The Invoice

b.1 What is an Invoice for?

The Invoice is the aid used by the care provider contracted by your HMIS for obtaining reimbursement of the cost of care they delivered to your beneficiaries. It allows the provider to add up all the care delivered to your members and the respective amounts over a given period. The Invoice, once accomplished is sent to your HMIS, which knows exactly how much it must reimburse. For your HMIS, the Invoice is an accounting record that justifies the outflow of your HMIS money on a given date from the cash you have on hand or from your bank

account. It also fosters appropriate monitoring of your activities as HMIS, since it summarizes the number and type of transactions and the expenditure your HMIS incurred with a given provider over a given period – usually, a month.

b.2 What does an Invoice contain?

Since the methods of payment of care providers may vary according to the nature of the provider and its agreement with your HMIS, the Invoice also functions in different ways:

For the health center:

- An amount per bout of illness: the center receives an amount that covers outpatient care, medicines and laboratory analyzes per case of illness. The advantage of this system is that patients' ongoing treatment is not interrupted due to lack of funds.
- An amount per consultation: this includes the cost of medicines and laboratory analyzes. The first consultation is often costlier than subsequent ones.
- A lump sum per person registered in the center: after registration, the center undertakes care for the beneficiary for a given period (generally one year) for a lump sum, irrespective of the care required.

For the hospital:

- A lump sum per day's hospitalization: this sum includes both accommodation and medical, surgical and nursing care, technical treatments and medicines.
- A lump sum covering all the time in hospital: a single amount calculated on the basis of an estimation of the average duration of hospitalization.
- A payment per benefit or per treatment: all accommodation medical treatment, and medicines are invoiced separately
- A payment per grouped benefit: all medical treatment, accommodation and medicines are grouped in the invoice for outpatient care, hospitalization, deliveries, transports.

In order to fulfil its different functions, the invoice must contain the following information:

Information on the Provider:

- details of the care provider
- number of the invoice
- period concerned/covered
- date when the invoice is issued
- who the invoice is to be sent to

Information on the Care Invoiced (per benefit):

- date of treatment
- identification of beneficiary: beneficiary code

- number of certificate of entitlement
- nature and cost of benefits: hospitalization, medicines analyzes, external care, with breakdown as to beneficiary

Other information:

- total amount of invoice in figures and words
- signature of provider: competent person of the health structure (senior doctor, duty nurse, competent administrative staff member).

Note that the HMIS does not always meet all the medical costs. A co-payment in the form of a patient's contribution, excess, lump sum or other amount is generally the beneficiary's responsibility. This co-payment will not be charged to the HMIS account because it has been paid by the beneficiary, and should therefore not be included in the amount to be reimbursed by the HMIS. To foster sound monitoring of the HMIS, this co-payment should appear on the Invoice for each beneficiary. This allows the HMIS to keep track of the whole cost of the care rather than only the part it pays.

b.3 How is the Invoice used?

The Invoice is an important reference document for you . In the MOA, it is important that you specify the provider's obligation to detail the costs to be met. A sample Invoice should be discussed with the care provider when drawing up the MOA. Your HMIS therefore should constantly possesses the information necessary to monitor the benefits given, which would not be possible if the provider altered the way of completing the invoice every month.

The Invoice is generally drawn up on a monthly basis. In the MOA, however, certain providers may opt to establish the Invoice according to the number of times care is provided (one Invoice every 100 treatments, for example), or the amounts to be reimbursed (one invoice as soon as the total amounts to be reimbursed reach Php 50,000, for example).

The Invoice is drawn up in two copies: one is sent to your HMIS while the other is retained by the provider. When you reimburse the care provider, you need to mark the reference indicating the date and methods of payment (cash, by transport or by cheque) on both copies of the Invoice.

The example presented below makes it possible for you to sum up the number of times costs are met and the monthly expenditure covered - direct payment system - by your HMIS with a care provider. The Invoice is based on the existence of Certificate of Entitlement - Certificate of Care Section which provides more accurate details of costs by type of treatment provided (e.g. hospitalization, examinations, etc.). If the system set up does not include Certificate of Care Section, the Invoice must be more detailed to show the expenditure covered per treatment. You then need to file these Invoices.

In the given example, the service provider (Health Center) sends an Invoice (per grouped benefit) with the following information, according to the MOA:

- outpatient care: 50% paid for by the HMIS
- transports: 50% paid for by the HMIS

- simple delivery: 80% paid for by the HMIS
- hospitalization: 80% paid for by the HMIS

As agreed, no later than the tenth of each month the Health Center submits Invoices for the different benefits provided, indicating: the date of treatment, the beneficiary code, the number of the Certificate of Entitlement, the nature of benefits and their cost for the HMIS and for beneficiaries. It also grants the HMIS a 10% reduction in the overall amount of the benefits.

b.4 Example of Invoice (Direct Payment System with Patient's Contribution): Please refer to Annex 3.9 for the actual sample of an HMIS Invoice.

Document 3.4.3.c: The Register of Benefits

c.1 What is the Register of Benefits for?

The Register of Benefits makes it possible for you to keep track of all benefits received by the beneficiaries of your HMIS. It is also called the 'register of health expenditure or 'benefit records.' This register makes it possible to know the following:

- the most frequent benefits
- the monthly/annual amount of benefits: periods of epidemics or other
- the average cost of benefits
- the utilization rate of health services
- respect for the agreement with the health facility
- the most frequently visited health facility
- the age, sex, occupation, geographic location of the highest-risk beneficiaries

Certain HMIS also work with Benefit Records. Each record contains the beneficiary's details and the monitoring of benefits consumed. This Guide recommends the use of a register.

c.2 What information does the Register of Benefits contain?

The Register of Benefits contains the following information:

- date
- number of certificate of entitlement
- beneficiary code
- invoice number
- origin of invoice: name of care provider
- amount payable: MHIS/beneficiary/total
- observations

You may organize the details of the register of benefits so that each new page of the register

represents another type of service. If it is convenient, your HMIS and the service provider may also code the benefits. Depending on your needs, you may also organize the benefit information according to the care provider or according to beneficiary sub-groups (e.g. by *barangay*, by sub-office, by age group or others).

c.3 How is the Register of Benefits used?

After receiving the Invoice from your care provider, your HMIS must record the expenditure in the Register of Benefits. You need to verify the number of the Certificate of Entitlement (Beneficiary Profile Section and the Certificate of Care Section) and the nature of the benefits before paying the invoices.

c.4 Example of Register of Benefits: Please refer to Annex 3.10 for the actual sample of an HMIS' Register of Benefits.

Table 3.8: The Recording of Benefits (The Register of Benefits)

Health Micro-Insurance Scheme Internal Organisation				External partners	
Beneficiary	**Executive Body**	**Board of Directors**	**Auditing Body**	**Providers**	**Savings Bank**
	(1) Pay invoice ↓ (2) Record in Register of Benefits →		(3) Control accuracy of information		

Annex 3.1: An Example of HMIS By-Laws

DRAFT BY-LAWS

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TITLE I: GENERAL PROVISIONS

CHAPTER 1 : INCORPORATION AND OBJECT OF THE HEALTH MICRO-INSURANCE SCHEME

Article 1 : At the level of the _____Federation of Women, a structure called a Health Micro-Insurance Scheme is hereby established as a non-profit making group of people whose primary object is solidarity and mutual assistance between its members.
(1) It shall be known as '_____HMIS';
(2) Its duration is unlimited;
(3) The registered office is in front of the town council. This may be transferred to any other place by a decision of the General Assembly.

Article 2 : The object of the health micro-insurance scheme is to pursue the business of foresight, solidarity and mutual assistance in favour of its members, particularly by means of action relating to:
(1) information, awareness-raising and risk prevention;
(2) assistance in terms of health;
(3) training.

Article 3 : The _____ Health Micro-Insurance Scheme undertakes not to participate in any religious, political or ethnic issue. It may, however, maintain co-operative relations with any group, organization, association or trade union in pursuit of its objectives.

CHAPTER 2 : ADMISSION, WITHDRAWAL, SUSPENSION, DEREGISTRATION AND EXCLUSION

SECTION 1 : ADMISSION

Article 4 : The _____ health micro-insurance scheme consists of honorary members and ordinary members (or adherents).

Article 5 : The title of honorary member may be granted by the General Assembly on the proposal of the Board of Directors to people who have provided exceptional services to the _____ health micro-insurance scheme or to the cause of mutuality, or at international level. Honorary members are not subject to any conditions regarding age, residence, profession or nationality. The number of honorary members may not exceed 50.

Article 6 : Ordinary members or adherents are people who have been granted the right to join and who, by regular payment of their contributions, allow the _____ health micro-insurance scheme to carry out its obligations towards its members.

Article 7 : The health micro-insurance scheme may not use paid intermediaries to recruit members or award remuneration according to the number of members or contributions paid.

Article 8 : Members of the health micro-insurance scheme and their families may benefit from the services of the health micro-insurance scheme. Admission is individual and voluntary and is obtained by applying in writing to the Board of Directors.

SECTION 2 : WITHDRAWAL, SUSPENSION, DEREGISTRATION, EXCLUSION

Article 9 : Any member may leave the health micro-insurance scheme by sending notice of their withdrawal in writing to the Board of Directors, though any members who withdraw may not re-join the health micro-insurance scheme.

Article 10 : The Board of Directors may at any time suspend any members whose conduct is detrimental to the proper functioning of the health micro-insurance scheme. Only the General Assembly is authorized to announce such suspensions.

Article 11 : Members who no longer comply with the conditions to which these statutes subject their admission shall be deregistered. Their deregistration shall be declared by the Board of Directors and shall be ratified by the General Assembly. Members who have not paid their contributions for six months shall be deregistered. Such deregistration shall come into effect following notification in writing of a warning in the third (3rd) month, followed by a letter explaining the reasons from the sixth (6th) month.

Article 12 : Members who have voluntarily caused duly ascertained damage to the interests of the health micro-insurance scheme (such as fraud or embezzlement) may be excluded.

Article 13 : Withdrawal, deregistration and exclusion shall not grant any entitlement to payment.

TITLE II : ADMINISTRATION OF THE HEALTH MICRO-INSURANCE SCHEME: COMPOSITION, ELECTION AND POWERS OF THE MANAGEMENT BODIES

CHAPTER 1 : THE GENERAL ASSEMBLY (GA)

Article 14 : The management bodies forming the health micro-insurance scheme are:
(1) The General Assembly
(2) The Board of Directors;
(3) The Auditing Body;
(4) The Executive Body.

Article 15 : The GA shall be made up of members delegated from basic groups. They shall be elected for one (1) year, in accordance with the normal procedure of the _____ Federation of Women.

Article 16 : Each basic group elects delegates who shall be chosen from the members of the functional management bodies of the health micro-insurance scheme (BD, AB or EB). Each delegate shall have one vote.

Article 17 : The GA is the highest authority of the health micro- insurance scheme. It shall meet once per year in ordinary session and extraordinarily whenever necessary, on the proposal of the Executive Body, the AB or 2/3 of its members.

Article 18 : Convening notices shall set out the agenda, the date and venue of the GA and shall reach addressees two weeks in advance.

Article 19 : The GA of the _____ health insurance scheme may not validly deliberate unless half its members are present or represented. If this condition is not fulfilled a second GA shall be convened fifteen (15) days later in the same conditions as the first. It shall deliberate validly, irrespective of the number of members present.

Article 20 : Decisions shall be taken by a simple majority of votes cast forimportant matters: alterations to the statutes, exclusion of a member, winding the health micro-insurance scheme up. They are pre-eminent and not subject to appeal. Any decision taken during a GA which has not been properly convened shall be null and void. Minutes of each session of the GA shall be drawn up.

Article 21 : The GA shall define the mission of the health micro-insurance scheme and shall formulate its general policy. It shall:
(1) Approve and alter the By-Laws;
(2) Examine and approve the activity reports of the various management bodies;
(3) Elect the members of the management bodies;
(4) Establish the membership fees and monthly contributions;
(5) Study the balance sheet submitted by the Board of Directorsand approve the new programme of action.

CHAPTER 2 : THE BOARD OF DIRECTORS (BD)
Article 22 : The GA may delegate part of its powers to the BD.
Article 23 : The _____ health micro insurance scheme shall be run by a BD composed of 15 people who shall be elected for three years.
Article 24 : Eligible members must be up-to-date with their contributions. Outgoing members may be re-elected.
Article 25 : The BD shall meet when convened by the Chairperson and at least once per month. It shall be convened obligatorily when so requested by half the members of the Board.
Article 26 : The BD may not validly deliberate unless at least half its members are present. No member of the Board may have more than one vote. Decisions shall be taken by a majority. In the event of equality the Chairperson shall have the casting vote. Each meeting shall be ratified by minutes approved by the BD at the following session.
Article 27 : The BD shall enjoy all the powers not expressly set aside for the GA by these By-Laws. It shall ensure the management of the health micro-insurance scheme and the implementation of its programmes and budget. Its activities shall be recorded in a report submitted to the GA.
Article 28 : The BD may delegate part of its powers under its responsibility and control.
Article 29 : The functions of members of the BD are unpaid. Certain representation expenses may be reimbursed.

CHAPTER 3 : THE AUDITING BODY(AB)
Article 30 : The AB shall be composed of four (4) members, one of whom shall be a coordinator and one a secretary. They shall be elected by the GM for three years.
Article 31 : The AB shall meet every month and shall draw up duly signed and dated minutes and shall verify the accuracy of the information recorded on the monthly monitoring record of the health micro-insurance scheme. It shall report to the GA.
Article 32 : The AB is responsible for ensuring that the acts of the health micro-insurance scheme comply with the regulations, verifying the accuracy of the accounts and the regularity of financial transactions. In exercising its functions it may call upon other internal or external abilities.
Article 33 : The AB may if necessary convene a Special GM.

CHAPTER 4 : THE EXECUTIVE BODY (EB)
Article 34 : The Executive Body is composed of:
(1) A Chairperson;
(2) A Vice-Chairperson;
(3) A Secretary and Deputy;
(4) A Treasurer and Deputy;
(5) A person responsible for education and promotion;

(6) Coordinators.

Article 35 : The Chairperson of the health micro-insurance scheme shall convene and chair meetings of the GA, BD and EB. He or she shall manage relations with the health centers to which the health micro-insurance scheme is connected by agreement, and with other providers who work with the latter. The Vice-Chairperson shall support and replace the Chairperson if the latter is unexpectedly prevented from acting, with the same powers.

Article 36 : Under his/her responsibility and control and with the authorization of the BD, the Chairperson may delegate some of his/her tasks.

Article 37 : The Secretary, in co-operation with her or his deputy, shall draft the minutes of the different meetings held within the health micro-insurance scheme. He or she shall ensure the ordinary correspondence of the health micro-insurance scheme, file and k e e p records, and issue the different documents relating to the health micro insurance scheme's operation.

Article 38 : In co-operation with his/her deputy the Treasurer shall ensure that the cash flow of the health micro-insurance scheme is recorded and shall participate in seeking ways to increase resources. The Treasurer shall draw up and present the financial reports and shall sign the accounts with the Chairperson or his/her replacement.

Article 39 : The person responsible for education and promotion shall ensure the education and training of members, and shall organize activities to promote the health micro-insurance scheme, in cooperation with the coordinators.

Article 40 : The coordinators are responsible for assisting the EB, particularly the person responsible for education and promotion, in their coordination, awareness-raising, education and guidance work.

Article 41 : The Manager is responsible for attending the meetings of all management bodies and for co-operating with them in executing their respective tasks. He/she shall, however, work under the control and supervision of the BD.

Article 42 : The EB shall keep a Cash Journal and a Cash-in-Bank Journal and shall ensure that the financial tools and statements are presented at the beginning and end of each financial year.

Article 43 : Meetings of the EB shall be held every month or when expressly convened by the Chairperson or two-thirds (2/3) of the members.

TITLE III : FINANCIAL PROVISIONS

CHAPTER 1: REVENUE AND EXPENDITURE

Article 44 : The revenue of the health micro-insurance scheme comprises:
(1) Members' admission fees and contributions;
(2) Donations and legacies;
(3) Subsidies granted by the government, local authorities or individuals;
(4) Interest on funds invested or disposed of;
(5) Revenue from events or voluntary contributions organized for the benefit of the health micro- insurance scheme;
(6) Any other revenue not prohibited by law.

Article 45 : Expenditure comprises:
(1) Meeting the cost of the healthcare described in the annex to the Policies, Systems and Procedures;
(2) Operating expenses;

(3) Contributions paid to unions;
(4) Any other expenditure not prohibited by law.

CHAPTER 2 : METHODS OF INVESTING AND WITHDRAWING FUNDS

Article 46 : The BD shall decide on investments and withdrawals of the health micro-insurance scheme funds, bearing the guidelines established by the GA in mind.

Article 47 : Expenditure shall be ordered by the Chairperson or their replacement and shall be made by the Treasurer or their deputy.

Article 48 : 30% of the surpluses of the financial year shall be allocated to reserves. Withdrawals from these reserves shall no longer be obligatory when the amount of the reserve fund reaches three-quarters of the total benefits actually given over to the health micro-insurance scheme during the preceding financial year.

TITLE IV: OBLIGATIONS OF THE HEALTH MICRO-INSURANCE SCHEME AND ITS MEMBERS

CHAPTER 1 : OBLIGATIONS OF MEMBERS

Article 49 : Members shall pay a non-returnable membership fee of Php1000.

Article 50 : Members undertake to pay a monthly contribution of Php 200.
This amount may be reviewed by the GA. Special contributions whose amount and types are established by the GA shall be added to the contribution.

Article 51 : Any unjustified delay of three (3) months in the payment of contributions shall give rise to a 25% increase in the amount owed.

Article 52 : In order to enjoy the benefits of the health micro- insurance scheme, members must be up-to-date in the payment of their contributions on the date of delivery of the care.

Article 53 : Entitlement to benefits takes effect from the end of the waiting period of three (3) months.

CHAPTER 2 : OBLIGATIONS OF THE HEALTH MICRO-INSURANCE SCHEME

Article 54 : The Policies, Systems and Procedures specify the methods of meeting beneficiaries' costs.

Article 55 : The benefits granted by the health micro-insurance scheme are agreed every year by the BD in agreement with the care providers.They shall be set down in a document available to everyone.

TITLE V : RULES OF APPLICATION, AMENDMENTS, MEMBERSHIP OF UNIONS, FEDERATION, MERGER, WINDING-UP AND LIQUIDATION

CHAPTER 1 : RULES OF APPLICATION AND AMENDMENTS

Article 56 : The Policies, Systems and Procedures established by the BD and approved by the GA determine the conditions of application of these By-Laws. All members shall comply with them in the same way as the By-Laws. The BD may make alterations to the Policies, Systems and Procedures which shall apply immediately. They shall be submitted for application at the next GA.

Article 57 : Only the GA may alter the By-Laws, on the proposal of the BD or two-thirds of the GA.

CHAPTER 2 : MEMBERSHIP OF UNIONS AND MERGER

Article 58 : The health micro-insurance scheme may join one or more unions on the decision of the GA. The unions may form into a federation of health micro-insurance schemes with a

view to pursuing the same ends.

Article 59 : The merger of the health micro-insurance scheme with one or more health micro-insurance schemes shall be decided by the GA. This decision shall be ratified at a Special GA convened specifically for this purpose.

CHAPTER 3 : WINDING-UP AND LIQUIDATION

Article 60 : The voluntary winding-up of the health micro-insurance scheme may be decided only by a Special GA convened for this purpose by means of a notice indicating the object of the meeting. A 2/3 majority of the members must be present.

Article 61 : In the event of winding up, the GA shall decide on the use to be made of the funds and assess the health micro-insurance scheme, in compliance with the HMIS spirit.

Annex 3.2: An Example of HMIS Policies, Systems and Procedures

_____HEALTH MICRO-INSURANCE SCHEME POLICIES, SYSTEMS AND PROCEDURES

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TITLE I : GENERAL PROVISIONS

CHAPTER 1 : INCORPORATION AND OBJECT OF THE HEALTH MICRO-INSURANCE SCHEME

Article 1 : These Policies, Systems and Procedures complete the By-Laws of the _____ HMIS. All ordinary members shall comply with them in the same way as the By-Laws.

Article 2 : The object of the health micro-insurance scheme is to promote mutual assistance and solidarity towards its members, insurance, healthcare and health education.

Article 3 : The health micro-insurance scheme includes members and their dependents as beneficiaries. The latter category of member may not participate in but may attend voting.

Article 4 : A Membership Book is issued to each member and an honorary membership book is issued to all honorary members.

CHAPTER 2 : ADMISSION, WITHDRAWAL, SUSPENSION, DEREGISTRATION AND EXCLUSION

SECTION 1 : ADMISSION

Article 5 : Persons meeting the following conditions may join the health micro-insurance scheme:
(1) People who enjoy all civic and civil rights.
(2) People who enjoy all mental and physical faculties.
(3) People who pay the membership fees of Php 1,000.

SECTION 2 : WITHDRAWAL, SUSPENSION, DEREGISTRATION, EXCLUSION

Article 6 : Withdrawal is free and voluntary. It shall be sent in writing to the Board of Directors, who shall take formal note of it, but it will be examined by the GA.

Article 7 : A member shall be suspended in the event of committing an offense or if their conduct does not conform to the rules. Suspension may be declared by the Board of Directors or the General Assembly.

Article 8 : Members who no longer comply with the conditions to which their membership is subject shall be deregistered. They shall be notified of the deregistration by the Board of Directors. Ordinary members who have not paid their contributions for the last six (6) months shall also be deregistered.

Article 9 : Members who have voluntarily caused duly ascertained damage to the interests of the HMIS (such as fraud or embezzlement) may be excluded. Members are given notice to appear before theBoard of Directors to have the facts they are accused of considered. If they fail to appear on the day indicated, new notice is sent to them. If they again decline to attend, the Board of Directors may declare their exclusion and they will be notified accordingly in writing.

Article 10 : Dismissal, deregistration and exclusion do not entitle the persons concerned to any repayment of contributions or membership fees.

TITLE II : ADMINISTRATION/FUNCTIONING OF THE HEALTH MICRO-INSURANCE SCHEME: COMPOSITION, ELECTION AND POWERS OF THE MANAGEMENT BODIES

CHAPTER 1 : MANAGEMENT BODIES OF THE HEALTH MICRO- INSURANCE SCHEME

Article 11 : The management bodies of the health micro-insurance scheme are:
(1) The General Assembly (GA).
(2) The Board of Directors (BD).
(3) The Auditing Body(AB).
(4) The Executive Body (EB)

Article 12 : An optional management body may be created if deemed necessary.

Article 13 : The members of the BD and the AB come from the GA, while those of the EB are chosen from among the directors.

CHAPTER 2 : OPERATIONS

Article 14 : The delivery of a certificate of entitlement by the health micro-insurance scheme shall be subject to the following conditions:
(1) All the people recorded in the family record must be up-to-date with their contributions.
(2) The waiting period must have concluded.
(3) For hospitalizations, a hospitalization ticket provided by the doctor from the approved center or any other qualified medical authority must be presented.

(4) If deemed necessary by the EB, the letter of commitment must be signed.
In the event of an emergency the beneficiary shall present theirMembership Book showing that their contributions are up-to-date and shall deposit the certificate of entitlement duly signed by the health micro- insurance scheme within 24 hours of the first contact.

Article 15 : The beneficiary shall comply with the commitments set down in the letter of commitment, failing which legal action may be brought against them.

Article 16 : Failure to respect the undertakings laid down in Article 15 shall involve the immediate suspension of the member from entitlement to benefits prior to any other action that may be initiated.

Article 17 : The decisions of the management bodies are pre-eminent and shall be approved by the GA. The EB is, however, under the control of the BD.

Article 18 : The Chairperson of the BD, the Treasurer and the manager may not be relatives or relatives by marriage in the first degree.

Article 19 : The management bodies of the health micro-insurance scheme shall function according to the procedures set down in the By-Laws.

Article 20 : The members of the various management bodies composing the _____ HMIS shall comply with their duties, subject to the penalties established for this purpose (see the By-Laws).

Article 21 : For the first five years after the incorporation of the health micro-insurance scheme, the _____Women's Federation is guaranteed that the management bodies of the _____ health micro-insurance scheme will function regularly and normally. The federation is qualified to take protective measures, if necessary, in accordance with the regulations governing mutual health insurance schemes.

CHAPTER 3: ELECTION

Article 22 : Elections of members of the management bodies shall take place democratically and transparently, and in accordance with the normal rules of the _____Women's Federation.

Article 23 : Voting by proxy is authorized only in exceptional cases (authorized absence, illness, justified incapacity, etc). One person may not receive more than one proxy.

TITLE III : FINANCIAL PROVISIONS

CHAPTER 1 : REVENUE AND EXPENDITURE

Article 24 : The membership fees are set at Php 1,000.

Article 25 : The amount of the monthly contribution is set uniformly at Php 200. Members are, however, encouraged to pay the total amount of their contribution for several months or one year in a single lump sum.

Article 26 : Contributions are paid in exchange for a receipt or supporting document no later than five (5) days after the meeting of the group.

Article 27 : Any members responsible for arrears of one month in the payment of contributions may not use the benefits for a period of 30 days after settling all the sums owed. Any member with arrears of six months in their contribution shall be deemed to have withdrawn.

CHAPTER 2 : METHODS OF INVESTING AND WITHDRAWING FUNDS

Article 28 : Funds may be withdrawn subject to the joint signature of two of the following four people: the Chairperson, the Treasurer, the Vice-Chairperson or the Deputy Treasurer

of the BD of the health micro-insurance scheme.

Article 29 : The execution of certain expenditure may be delegated by the Chairperson or the Treasurer to the manager or his/her assistant.

TITLE IV : OBLIGATIONS OF THE HEALTH MICRO-INSURANCE SCHEME AND ITS MEMBERS

CHAPTER 1 : OBLIGATIONS OF MEMBERS

Article 30 : Members shall pay a non-returnable membership fee Of Php1,000 and shall provide identification photo-graphs of all beneficiaries to be in the Membership Book. The personal details of each beneficiary are set down in this Membership Book.

Article 31 : Members undertake to pay a monthly contribution, set at Php 200 per beneficiary, before the 10th of each month. The number of dependents is limited to 18 per member.

CHAPTER 2 : OBLIGATIONS OF THE HEALTH MICRO-INSURANCE SCHEME

Article 32 : Any ordinary member may benefit from the ff services:
(1) The benefits offered by the HMIS;
(2) Joint benefits to a deceased member's beneficiaries, the amount of which shall be determined by the BD according to existing financial resources.

Article 33 : The people set down on the register of beneficiaries whose contributions are up-to-date are entitled to the benefits of the HMIS. Contributions are monitored by means of the Register of Contributions and MB.

Article 34 : A form summing up the services covered by the HMIS is annexed to these Policies, Systems and Procedures.

Article 35 : The HMIS shall ensure the quality of the care provided and shallensure good relations with the Health Center.

Article 36 : Any matter not covered in the By-Laws or the Policies, Systems and Procedures shall be examined by the BD.

TITLE V. AMENDMENTS

Article 37 : Only the GA may make alterations to these Policies, Systems and Procedures. The BD may, however, make alterations which shall apply immediately but which shall be submitted for ratification at the following GA.

ANNEX : THE SERVICES COVERED BY THE HEALTH IMICRO-INSURANCE SCHEME

By means of its agreement with the Health Center, the health micro- insurance scheme has obtained:

- a 10% reduction in the overall monthly benefits;
- the undertaking of _____ Health Center to ensure that any beneficiary of the health micro-insurance scheme is welcomed.

The health micro-insurance scheme undertakes to meet the costs of any beneficiary provided with:

- a numbered Certificate of Entitlement completed and signed by the Chairperson of the health micro-insurance scheme;
- a Membership Book in which he/she is included, with an initialled photograph and up-to-date contributions.

The following benefits are granted by the Health Center:

- outpatient care: 50% paid for by the health micro- insurancescheme;
- transport: 50% paid for by the health micro-insurance scheme;
- simple delivery: 80% paid for by the health micro-insurance scheme;
- hospitalizations: 80% paid for by the health micro-insurance scheme.

Annex 3.3: An Example of HMIS Minutes of Meeting

Health Micro-Insurance Scheme
Minutes N° : ……..

MINUTES OF MEETING

In the year……..on……., the meeting of the ……of the……..……of the Health Micro-Insurance Scheme was held at……..

The agenda was as follows:

1. ……..……
2. ……..……..
3. ……..……
4. ……..……

Number Attending : ……
Absentees Excused : ……
Absentees Not Excused : ……

The following decisions were taken:

- ……..……
- ……..……
- ……..……
- ……..……
- ……..……
- ……..……
- ……..……
- ……..……
- ……..……

Opened at ……..hours …..minutes. The session was closed at ….hours……. minutes on the above day, month and year

The Secretary: **Chairperson**

MODULE 3

Annex 3.4: An Example of HMIS Memorandum of Agreement

_____Health Micro-Insurance Scheme
Republic of the Philippines

_____
_____

Agreement

Between the _____Health Micro-Insurance Scheme and _____ Health Center

On 2 October 2002 the following is hereby established
Between
The _____ Health Micro-Insurance Scheme, represented by the Chairperson of the Board of Directors, Madame_____, and: _____ Health Center, represented by Dr._____.

Article 1: Object

The object of this Agreement is to define the conditions according to which care benefits are supplied by _____Health Center to the beneficiaries of the _____ Health Micro-Insurance Scheme.

Article 2: Commitments

2.1. The _____ Health Center commits itself to:
Welcome any beneficiary provided with a numbered Certificate of Entitlement, completed and signed by the Chairperson of the health micro- insurance scheme, and a Membership Book in which he/she is included with an initialled photograph, and showing that their contributions are up-to-date.

- Ensure that in the event of an emergency the beneficiary presents their Membership Book indicating that their contributions are up-to-date and files the Certificate of Entitlement duly signed by the health micro-insurance scheme within 24 hours of the first contact.
- Complete the Certificate of Care Section of the Certificate of Entitlement after treating the beneficiary.
- Provide quality health care to any beneficiary whose contributions are up-to-date, in accordance with the risks covered by the health micro- insurance scheme:
    - outpatient care: 50% paid for by the HMIS;
    - transports: 50% paid for by the HMIS;
    - simple deliveries: 80% paid for by the HMIS;
    - hospitalizations: 80% paid for by the HMIS.
- Prescribe medicines in generic form for beneficiaries in the first instance.
- Submit by the tenth of each month at the latest, the invoices for the different benefits provided, bearing: the date of treatment, the code of the beneficiary, the number of the Certificate of Entitlement, the nature of the benefits and their cost for the HMIS and the beneficiaries.
- Grant the HMIS a 10% reduction from the overall monthly benefits by means of a deposit of Php. 200,000.

2.2. The _____Health Micro-Insurance Scheme undertakes to:

- Honour invoices presented by the care provider within no more than 15 days of their receipt. Payment shall be made by bank transfer, cheque or cash.
- Deliver a Certificate of to beneficiaries whose contributions are up-to-date, to be presented to the care provider.
- Participate with and support the care provider in organizing information and disease-prevention activities.

Article 3: Duration

This Agreement shall have a duration of two years and may be tacitly renewed.

Article 4: Arbitration

Any dispute between the two parties shall be settled amicably, failing which it shall be submitted to the competent health and legal authorities.

Article 5: Termination

The agreement may be terminated at any time, providing the party which has taken the initiative to do so informs the other party three (3) months in advance in writing.

Article 6: Revision

This Agreement may be revised whenever necessary.

Article 7: Signature

This Agreement shall come into effect on the date of its signature by the two parties.

For the Health Center. For the Health Micro-Insurance Scheme

The senior doctor The Chairperson of the BD

Dr. _____ Mme_____

For the _____

ANNEX: COST OF BENEFITS OFFERED
PRICE OF TREATMENT

Description of Treatment	Price (in Php)
Adult consultation	150
Child consultation	100
Pre-natal consultation	100
Post-natal consultation	150
Family planning	50
Care with dressing/stitches	250
Injection	100
Vaccination	100
Vaccination record	100
Accommodation of patient per night	750
Simple delivery	4 000
Maternity record	50
Health transport with ambulance HC:	
- inside the catchment area	500
- up to 10 km outside	1 000

The overall cost of the treatment will depend on the duration and cost of the medicines used.

The _____Health Micro Insurance Scheme benefits from a reduction of 10% of the overall cost (which includes the above rates in force and all costs of supplementary medicines), in accordance with the agreement.

Annex 3.5: An Example of HMIS Membership Book

(1) The first example is a recommended format that contains the basic information in a membership Book.

Cover Page

Health Insurance Scheme

Membership Book

Name of Member:_____

Inside Cover Page

Monitoring Contributions

Year	Jan.	Feb.	Mar.	April	May

Monitoring Contributions

June	July	Aug.	Sept	Oct.	Nov.	Dec.

First Page: Identification of Member

Photo	**Member** Beneficiary Code: .....

First name: .....
Surname: .....
Identity Card N° : .....
Sex: .....
Address: .....
Telephone: .....
Date of Birth: .....
Place of Birth: .....
Blood Group: .....
Date of Joining: .....

Other Inside Pages: Identification of Beneficiaries

Photo	**Beneficiary** Beneficiary Code: .....

First name and surname: .....
Relation with member (parent, under .....
guardianship, other)
Identity Card N° :.....
Date and Place of Birth: .....
Blood Group: .....
Date of First Contribution: .....

Photo	**Beneficiary** Beneficiary code: .....

Relation with member (parent, :.....
under guardianship, other)
Identity Card N .....
Date and Place of Birth: .....
Blood Group: .....
Date of first contribution: .....

Other Pages (Optional) : Summary of Internal Rules of Procedures

Page 1:
Useful Information on the Health Micro-Insurance Scheme
Goal of the Scheme : The goal of the scheme is to improve access to healthcare by means of mutual assistance and solidarity among members. The scheme makes a distinction between members and their dependents.
Conditions of Membership : People who meet the following conditions may join the scheme

- those who comply with the HMIS legislative and regulations;
- those who pay the membership fees;
- those who undertake to contribute regularly to the HMIS

Page 2:
How can I obtain the services of the health micro- insurance scheme?
To obtain the benefits of the HMIS, I must:

- be up-to-date with my contributions;
- have concluded the waiting period;
- go to the HMIS with my Membership Book to obtain the Certificate of Entitlement, duly numbered, completed and signed by the person authorized by the HMIS.

Go to the provider with:

- the Membership Book;
- the Certificate of Entitlement

Page 3:
Benefits Offered:

_____
_____
_____

Providers:

_____
_____
_____

In the event of fraud, or delay of contributions, the HMIS refers to the penalties provided for in the Policies, Systems and Procedures.

(2) The following shows an example of a membership card used by the ORT-OHPS in San Fernando, La Union.

The ORT-OHPS Membership Card is a three-fold 3" x 11" card which contains the following information

Code No.:_____
Family No.:_____

MEMBERSHIP CARD

ORT Health Plus Scheme LOGO Partnership

O
H
P
S

"Paglaanan ang Kalusugan Para sa Magandang Kinabukasan"

Page 1

NAME OF MEMBER(PM) ☐ PHIC ☐ NPHIC

Last First M

NAME OF SPOUSE ☐ PHIC ☐ NPHIC

Last First M

FAMILY MEMBERS	AGE	BIRTHDATE	RELATIONSHIP	SIGNATURE

Untitled Dependents : (1) children 17 years old and above
(2) legally adopted children
(3) disabled children
(4) parents of PM 60 years old an above

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Date	Name	OPD C	OP D H	ER	LAB	COST	COV MEDS	COST	DOH	COST	TOTAL	MD/ NOD	SAT

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DATE OF REGISTRATION 1. _____ 3. _____
2. _____ **4.**_____

ENTRY STATUS ☐NEW ☐OLD ☐RE-ENTER

YEAR:			YEAR:	
JAN	JUL		JAN	JUL
FEB	AUG		FEB	AUG
MAR	SEP		MAR	SEP
APR	OCT		APR	OCT
MAY	NOV		MAY	NOV
JUN	DEC		JUN	DEC

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ORT HEALTH PLUS SCHEME
OHPS-ITRMC PARTNERSHIP
Guerrero Road, San Fernando City
Telefax: (072) 242-51-58
Clinic: 700-30-82 TIN: 003-983-068-NV

----- OHPS-----
MEMBERSHOP CARE

- This card is exclusive use of the member and beneficiaries.
- ALWAYS PRESENT THIS CARD PLUS ANY VALID ID FOR BENEFICIARIES WHEN AVAILING OF THE SERVICES COVERED BY THE AGREEMENT
- To avail of your benefits, pay your contribution on time.
- Report loss of this card immediately.

_____
Signature of Principal Member

Annex 3.6: An Example of HMIS Register of Beneficiaries

(1) The following are information about members of an HMIS to illustrate how the Register of Beneficiaries is accomplished.

Member 1: Juan de la Cruz
The manager records the membership of Juan de la Cruz by giving him a Beneficiary Code:
1/1/0s : first beneficiary
first member from Barangay San Nicolas)

The manager then records the following information on Juan dela Cruz in the Register of Beneficiaries and Membership Book:
- surname and first name
- sex
- address
- date of birth.

Member 2: Sandra de la Cruz
The manager then records Sandra de la Cruz as a dependant of Juan de la Cruz, giving her the Beneficiary Code:
2/1/0s - second beneficiary
- person dependant on first member, from Barangay San Nicolas

The manager also records all the information concerning them: sex, address and date of birth.

Member 3: Antonio Corpuz
He joined the HMIS on 2/10/00, is the third beneficiary of the HMIS, the second member and comes from Barangay an Felix (Beneficiary Code: 3/2/K).

2) Register of Beneficiaries: The informatiom are entered into the following registry.

Beneficiary Code	First Names and Surname	Sex	Address	Date of Birth	Status Member	Status Dependant	Date of Joining	Date of Leaving	Reason/ Observations
1/1/0s	Juan de la Cruz	M	Brgy. San Nicolas	22/10/67	X		1/10/00		
2/1/0s	Sandra de la Cruz	F	Idem	1/7/86		X	1/10/00		
3/2/K	Antonio Corpuz	M	Brgy. San Felix	2/10/72	X		2/10/00		
4/2/K	Sally Fernandez	F	Idem	28/2/72		X	2/10/00		

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3) The following is an actual example of Registry of Beneficiaries being used by ORT-OHPS in San Fernando, La Union, March 2004

ID No	Name	Satellite	Registration Date	Category	No.	Initial	Med	Last Payment	Amt	Reference	Mem
102289301	Esguerra, Fe	CU	07/10/2002	2	3	☐	☐	March 4	120	P	A
13210201	Eslaya, Jacinto	Nadsaag	07/07/1994	2	4	☐	☐	Feb 4	240	P	A
1712909121	Espejo, Estelita	Bariquir	07/21/2003	1	1	☐	☐	Jan 4	210	P	W
1722109171	Espejo, Rodolf	Bariquir	07/12/2003	2	3	☐	☐	Jan 4	360	P	W
15210601	Esperon, Lolita	Bulala	08/01/1994	2	3	☐	☐	Feb 4	240	P	W
1722109201	Espino, Irma	Bariquir	08/06/2001	2	3	☐	☐	Feb 4	240	P	W
1722109071	Spino, Jennie	Bariquir	07/08/1994	2	5	☐	☐	Jun4		P	A
						☐	☐				
						☐	☐				
						☐	☐				
12210801	Fontanilla, Elisa	San Francisco	07/17/2003	2	6	☐	☐	March 4	120	P	A

Register of Benefits

Type of Service: Delivery

Date of Treatment	N° Certificate of entitlement	Beneficiary Code	Invoice: N°	Invoice source	Amount Payable (in Php.)			Observations
					HMIS	Beneficiary	Total	
5/1/02	5/2002	24/6/K	16	RHU San Nicolas	5 000	1 250	6 250	
2/2/02	27/2002	207/85/Os	17	RHU San Nicolas	3 000	3 000	6 000	
17/2/02	31/2002	150/68/K	17	RHU San Felix	5 000	5 000	10 000	
21/2/02	35/2002	131/60/Os	17	RHU San felix	4 000	4 000	8 000	
….								
Total					…	…	…	

Annex 3.7. An Example of HMIS Register of Contributions

Member's Code	First names Surname	Name of Beneficiaries	Monthly Contributions	Possible Arrears Previous Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct Nov	Dec	End of Year Arrears

Annex 3.8. An Example of HMIS' Certificate of Entitlement

HEALTH MICRO-INSURANCE SCHEME

CERTIFICATE OF ENTITLEMENT NO._____

BENEFICIARY PROFILE SECTION
Place:_____
Name of Member:_____

Code
No.:_____
Date of Birth:_____
Sex:_____
Address:_____
_____
Benficiary Code No.:_____
The_____
For the HMIS

HEALTH MICRO-INSURANCE SCHEME

CERTIFICATE OF ENTITLEMENT NO._____

GUARANTEE SECTION

_____

According to the agreement signed between you and the HMIS, please meet the costs of the Beneficiary identified below amd send us the Invoice accompanied by the Certificate of Care Section.

The_____
Chairperson for the HMIS

HEALTH MICRO-INSURANCE SCHEME
CERTIFICATE OF ENTITLEMENT NO._____
CERTIFICATE OF CARE SECTION

Name of Beneficiary:_____
Code No.:_____
Beneficiary Code:_____
Name of Beneficiary:_____

Care Provided:_____
Name of Beneficiary:_____
- Total Cost Care_____
- Amount paid per beneficiary_____
- Amount payable to HMIS_____
The_____
For the Provider

Annex 3.9. An Example of HMIS Invoice (Direct Payment System with Patient's Contribution)

Health Center Date: 10/11/2002

Number: 25

To the _____Health Insurance Scheme

INVOICE

Period covered: 1/10-1/11/2002

Date of Treatment	**Beneficiary Code**	**N° Certificate of Entitlement**	**Nature of Benefits**	**Cost of Benefits** (after reduction of 10%, in Php)		
				HMIS to Pay	**Benefits Paid**	**Total**
2/10/02	167/76/K.	120/2002	Hospitalisation	6 000	1 500	7 500
5/10/02	180/80/Os.	121/2002	Outpatient care	1 500	1 500	3 000
7/10/02	23/12/K.	123/2002	Outpatient care	500	500	1 000
7/4/02	12/5/Os.	122/2002	Outpatient care	1 000	1 000	2 000
8/4/02	50/20/K.	124/2002	Delivery	5 000	1 250	6 250
9/4/02	61/23/K	125/2002	Transport	3 000	3 000	6 000
10/4/02	220/91/S	127/2002	Outpatient care	1 200	1 200	2 400
11/4/02	210/86/K	126/2002	Outpatient care	1 000	1 000	2 000
12/4/02	4/1/Os	128/2002	Outpatient care	500	500	1 000
14/4/02	12/5/0s	129/2002	Outpatient care	1 500	1 500	3 000
17/4/02	19/6/K	130/2002	Outpatient care	1 000	1 000	2 000
21/4/02	182/80/0s	132/2002	Outpatient care	1 800	1 800	3 600
25/4/02	120/60/K	131/2002	Outpatient care	2 000	2 000	4 000
Total				26 000	17 750	43 750

This invoice is issued for the sum of: *Twenty Six Thousand Pesos.*

Signature of Provider: _____

The Invoice presents the sum of Php 26,000 to be paid by the HMIS for meeting the cost of 10 benefits of outpatient care, one delivery, one transport and one hospitalization. By means of the members' contribution system, the beneficiaries have participated in meeting the cost for an amount of Php 17,750.

Annex 3.10: An Example of HMIS Register of Benefits

In the example given below, the HMIS records the information from the monthly Invoices in the Register of Benefits. The page summarizes meeting the cost of deliveries with:

- a reference to the date,
- the number of the Certificate of Entitlement,
- the beneficiary code,
- the invoice number,
- the origin of the invoice (name of care provider),
- and the amount payable by the HMIS and the beneficiary, and the total

A column is provided for comments. These information correspond to the information on the invoice and on the Certificate of Entitlement-Certificate of Care Section.

At the end of the page (or at the end of the year), your HMIS must add up the expenditure connected to meeting the cost of deliveries by your HMIS and by the beneficiary respectively.