PACIFIC CROSS

CRITICAL COVER EXTRA

Critical Illness Insurance Rider

APPLICATION FORM

Directions: Please answer this Application Form as truthfully as possible. All sections must be completed. Please use block letters. Applicants may be required to provide Blue Cross with a Medical Examination Form from a General Practitioner in addition to the Application Form. The Medical Examination Form is available upon request from our Medical Sales Representatives.

PERSONAL INFORMATION: Principal Applicant

FIRST NAME:

MIDDLE NAME: LAST NAME:

MOTHER'S MAIDEN NAME:

BIRTHDATE: month day year SEX: ☐ Male ☐ Female WEIGHT: lbs. HEIGHT: feet inches

CIVIL STATUS: ☐ Single ☐ Married ☐ Widow/Widower ☐ Separated OCCUPATION:

FAMILY DOCTOR: Name:

Clinic/Hospital Address:

Telephone: Fax: Email:

DEPENDENTS TO BE INSURED

For Single Applicant - Please state names of immediate family members. For Married Applicant - Please state name of spouse first, followed by children (from eldest to youngest).

DEPENDENT 1 (i.e. Spouse)

Name: First Name Middle Name Last Name Date of Birth: month day year

SEX: ☐ Male ☐ Female WEIGHT: lbs. HEIGHT: feet inches OCCUPATION:

DEPENDENT 2

Name: First Name Middle Name Last Name Date of Birth: month day year

SEX: ☐ Male ☐ Female WEIGHT: lbs. HEIGHT: feet inches OCCUPATION:

PLAN DETAILS

Principal Applicant	Blue Royale Plan:	☐ Plan A	☐ Plan B	☐ Plan C
	Critical Cover Extra Sum Insured:	☐ $25,000	☐ $50,000	☐ $50,000
Dependent 1	Blue Royale Plan:	☐ Plan A	☐ Plan B	☐ Plan C
	Critical Cover Extra Sum Insured:	☐ $25,000	☐ $50,000	☐ $50,000
Dependent 2	Blue Royale Plan:	☐ Plan A	☐ Plan B	☐ Plan C
	Critical Cover Extra Sum Insured:	☐ $25,000	☐ $50,000	☐ $50,000

NOTE: Principal Applicants and dependents 18 years old and below can only choose $25,000 Sum Insured.

HOUSEHOLD ANNUAL SALARY

Directions: Please identify your Household Annual Salary range:

☐ PhP 300,000 and below
☐ PhP 300,001 to PhP 500,000
☐ PhP 500,001 to PhP 700,000
☐ PhP 700,001 to PhP 1,000,000
☐ PhP 1,000,001 to PhP 1,500,000
☐ Above PhP 1,500,000

Directions: Please answer the following questions for each person to be insured. For each YES response, kindly indicate the first name of the person concerned, specify the particular medical condition and provide complete details on the space provided on the next page.

	First Name of Applicant Age_____		First Name of Dependent 1 Age_____		First Name of Dependent 2 Age_____	
	YES	NO	YES	NO	YES	NO
1. At any given time, have you ever had symptoms of or been diagnosed or treated for any of the following illnesses?						
a. Any chest pain, heart disease or problems of the blood vessels? e.g., rheumatic fever, raised blood pressure, high blood cholesterol, angina, irregular heartbeat, murmur, heart attack etc.	❑	❑	❑	❑	❑	❑
b. Any chest or breathing complaint? e.g., asthma, bronchitis, tuberculosis, persistent hoarseness or cough, or other respiratory problems	❑	❑	❑	❑	❑	❑
c. Any complaint of the digestive system? e.g., hepatitis or hepatitis carrier, gallstones, gastric ulcer, esophageal reflux, polyps, bowel or rectal bleeding	❑	❑	❑	❑	❑	❑
d. Any diseases of the genital urinary system? e.g., blood or protein in urine, kidney stones, nephritis or nephropathy, renal failure, prostate disorders, ovarian cysts, endometriosis, etc.	❑	❑	❑	❑	❑	❑
e. Any neurological or mental disorders? e.g., epilepsy, impairments of hearing, speech or vision, prolonged headache, convulsions, depression, stroke, paralysis, multiple sclerosis, Parkinson's disease, Alzheimer's disease, etc.	❑	❑	❑	❑	❑	❑
f. Any endocrine disorders? e.g., diabetes, pituitary disorder, thyroid disorder	❑	❑	❑	❑	❑	❑
g. Chronic pain or other problem in your neck or back, ankylosing spondylitis, sciatica,muscle or joint disorders, gout, rheumatism, systemic lupus erythematosus, or other physical disability?	❑	❑	❑	❑	❑	❑
h. Cancer, tumor, lumps, cyst, disorder of skin, disorder of lymph gland, anemia, leukemia, other disorder of blood?	❑	❑	❑	❑	❑	❑
2. Have you been tested for HIV-antibodies? If YES, what was the result?	❑ ❑HIV-Positive ❑HIV-Negative	❑	❑ ❑ HIV-Positive ❑ HIV-Negative	❑	❑ ❑HIV-Positive ❑HIV-Negative	❑
3. Do you take or have you taken any kind of medicine on a regular basis? (If Yes, please list name of medicine & dosage, and since when you have been taking the medicine on the space provided on page 4.)	❑	❑	❑	❑	❑	❑
4. Have you ever received medical advice or counseling in connection with hepatitis, HIV/AIDS or any sexually transmitted conditions?	❑	❑	❑	❑	❑	❑
5. Have you been a patient in a hospital, clinic or sanitarium at any given time?	❑	❑	❑	❑	❑	❑
If YES, do you suffer any consequence or sequelae from the condition/s? (If Yes, please provide details of the medical condition on page 4.)	❑	❑	❑	❑	❑	❑
6. Are you planning a medical consultation or treatment? (If Yes, please state your reason on the space provided on page 4.)	❑	❑	❑	❑	❑	❑
7. Have you ever been, or are you currently a smoker?	❑	❑	❑	❑	❑	❑
a. If yes, for how long?	____ years		____ years		____ years	
b. If still a smoker, how many cigarette sticks per day?	____ cig. sticks		____ cig. sticks		____ cig. sticks	
c. If you have stopped smoking, please state the date and reason.	Date:_____ Reason:_____		Date:_____ Reason:_____		Date:_____ Reason:_____	
d. Did you receive medical advice to stop smoking? (If Yes, please state the reason on the space provided on page 4)	❑	❑	❑	❑	❑	❑
8. Do you drink alcohol or ever regularly drink alcohol? If YES,	❑	❑	❑	❑	❑	❑
a. Please state type (spirits, wine, beer, etc.).	_____		_____		_____	
b. Please state quantity (centiliter, units, glasses, bottles, etc.) per week.	_____		_____		_____	
c. If you have stopped drinking, please state the date and reason.	Date:_____ Reason:_____		Date:_____ Reason:_____		Date:_____ Reason:_____	
d. Did you receive medical advice to stop drinking? (If Yes, please state the reason on the space provided on page 4)	❑	❑	❑	❑	❑	❑

	Applicant		Dependent 1		Dependent 2	
	YES	NO	YES	NO	YES	NO
9. Have you ever used any habit-forming drugs or narcotics? (If Yes, please give details on the space provided on page 4.)	❑	❑	❑	❑	❑	❑
10. Have you lost or gained weight in the past year? (If Yes, please state the amount of weight loss/gain and reason on the space provided on page 4.)	❑	❑	❑	❑	❑	❑
11. Have your natural parents or siblings had any of the following illnesses?						
a. Diabetes	❑	❑	❑	❑	❑	❑
b. Cancer(s)						
b1. Breast	❑	❑	❑	❑	❑	❑
b2. Cervical	❑	❑	❑	❑	❑	❑
b3. Ovarian	❑	❑	❑	❑	❑	❑
b4. Colon	❑	❑	❑	❑	❑	❑
b5. Other Cancer(s)	❑	❑	❑	❑	❑	❑
c. High blood pressure	❑	❑	❑	❑	❑	❑
d. Heart problems	❑	❑	❑	❑	❑	❑
e. Stroke	❑	❑	❑	❑	❑	❑
f. Haemochromatosis	❑	❑	❑	❑	❑	❑
g. Huntington disease (Huntington's Chorea)	❑	❑	❑	❑	❑	❑
h. Polycystic kidney disease	❑	❑	❑	❑	❑	❑
i. Multiple sclerosis	❑	❑	❑	❑	❑	❑
j. Mental disease	❑	❑	❑	❑	❑	❑
k. Any other hereditary disease(s)	❑	❑	❑	❑	❑	❑
If Yes, please provide relationship, condition, age at onset and/or age at death (if applicable) on the space on page 5.						
12. Have you been on sick leave for more than two consecutive weeks at any given time? (If Yes, please state the diagnosis and confinement period on the space provided on page 4.)	❑	❑	❑	❑	❑	❑
13. Have you been advised to have or are you intending to or have had any diagnostic tests at any given time such as but not limited to X-ray, mammography, electrocardiogram, stress test, CT scan, echocardiogram, ultrasonogram, blood or urine studies? (If Yes, please praovide details on the space provided on page 4.)	❑	❑	❑	❑	❑	❑
14. Insurance application/policy						
a. Has any of your medical, critical illness or life application been declined, rated or restricted?	❑	❑	❑	❑	❑	❑
b. Do you have any existing or pending application for Critical Illness coverage other than this application?	❑	❑	❑	❑	❑	❑
c. If you currently a have medical policy, have you claimed payment for any sickness, accident or injury?	❑	❑	❑	❑	❑	❑
(Please specify the insurance company, sum insured, application/policy effective date and reason on the space provided on page 5.)						
15. Do you engage in any form of sports? If Yes, speficy.	❑	❑	❑	❑	❑	❑
	_____		_____		_____	
	_____		_____		_____	
	_____		_____		_____	
NOTE: Question numbers 15 to 17 are to be completed by Female Applicants only.						
16. Have you ever had or been told to have, or been treated or intending to seek consultation/treatment for any disease/disorder of the cervix, uterus or the breast? (If Yes, please provide details of the medical condition on the space provided on page 4.)	❑	❑	❑	❑	❑	❑
17. Are you now pregnant?	❑	❑	❑	❑	❑	❑
If Yes, please state month(s) of pregnancy.	____ mos.		____ mos.		____ mos.	
18. Have you been informed by a doctor or is there any reason to believe that your pregnancy may be abnormal? (If Yes, please provide details of the medical condition on the space provided on page 4.)	❑	❑	❑	❑	❑	❑

DETAILS OF YES RESPONSES

If space is insufficient, please attach additional details.

Qstn No.	Details/Medical Condition	Nature/Date of Treatment	Current Status	Doctor's Name	Doctor's Current Info (Address, Phone No., Fax No.)
Name of Principal Applicant:					
Additional pages attached? ☐ YES ☐ NO		**Remarks (for Pacific Cross use only):**			
Name of Dependent 1:					
Additional pages attached? ☐ YES ☐ NO		**Remarks (for Pacific Cross use only):**			
Name of Dependent 2:					
Additional pages attached? ☐ YES ☐ NO		**Remarks (for Pacific Cross use only):**			

For Medical Questionnaire Item No. 3 (Medicine & Dosage), please provide details below.

Name of Medicine	Medical Condition	Date Since Applicant Has Been Taking the Medicine
Name of Principal Applicant:		
Additional pages attached? ☐ YES ☐ NO	**Remarks (for Pacific Cross use only):**	
Name of Dependent 1:		
Additional pages attached? ☐ YES ☐ NO	**Remarks (for Pacific Cross use only):**	
Name of Dependent 2:		
Additional pages attached? ☐ YES ☐ NO	**Remarks (for Pacific Cross use only):**	

For Medical Questionnaire Item No. 14 (Other Insurance Applications or Policies), please provide details below.

Relationship to Applicant eg. father, mother, sister, brother	Medical Condition	Nature/Date of Treatment	Current Status	Age at Time of Diagnosis	Age at Time of Death
Name of Principal Applicant:					
Additional pages attached? ☐ YES ☐ NO	**Remarks (for Pacific Cross use only):**				
Name of Dependent 1:					
Additional pages attached? ☐ YES ☐ NO	**Remarks (for Pacific Cross use only):**				
Name of Dependent 2:					
Additional pages attached? ☐ YES ☐ NO	**Remarks (for Pacific Cross use only):**				

For Medical Questionnaire Item No. 14 (Other Insurance Applications or Policies), please provide details below.

Qstn No.	Insurance Company	Sum Insured (if applicable)	Effective Date	Reason (if applicable)
Name of Principal Applicant:				
Additional pages attached? ☐ YES ☐ NO	**Remarks (for Pacific Cross use only):**			
Name of Dependent 1:				
Additional pages attached? ☐ YES ☐ NO	**Remarks (for Pacific Cross use only):**			
Name of Dependent 2:				
Additional pages attached? ☐ YES ☐ NO	**Remarks (for Pacific Cross use only):**			

DECLARATION

I understand that failure to answer truthfully the questions in this application, or concealment, or misrepresentation of any significant condition will result in the voiding of the applicable benefit under this plan. If my state of health changes after the Application Form has been signed and before Pacific Cross Insurance, Inc. has approved the insurance, I understand that I must notify Pacific Cross
Insurance, Inc. immediately of such a change. In this case and in case of other pre-existing conditions, I am required to enclose any relevant up-to-date medical reports.

I hereby authorize Pacific Cross Insurance, Inc. and all persons duly authorized and acting on their behalf to request and receive any information or document or record from any hospital, clinic, laboratory, attending physician and other health service provider, which information or document relates to any medical history, examination, laboratory test results and/or treatment in connection with this application form and any subsequent claim, such other matters related thereto. A photocopy of this authorization is considered an original for all intents and purposes.

I understand that this application form and all test results are subject to medical evaluation. I understand that premium loading may be applied subject to the results of the medical evaluation.

I declare that I have read all the particulars stated on all pages of this application form, and confirm that the answers and details written are complete and true, whether written by me or someone else on my behalf, and shall be binding on me.

DATA PRIVACY CONSENT: I understand that Pacific Cross collects and uses my personal data to service and administer my insurance policy, to provide appropriate and timely Medical Services, and for the purposes provided in the Pacific Cross Privacy Statement attached to this application form (also available at www.pacificcross.com.ph). By signing this application form, I acknowledge that I have read and agree to the terms of the Privacy Statement, and understand that my data may be collected, shared, disclosed, transferred, used or otherwise processed by Pacific Cross in accordance with the Data Privacy Act of 2012, its implementing rules and regulations, and the Privacy Statement. Nothing in this form is intended to revoke or supersede any prior consent that I have given to Pacific Cross in respect of the processing activities involving my personal data.

Signature over printed name of Applicant	If the insured is a minor, signature over printed name of Applicant - Payor (e.g. parent or guardian)	Date

PREMIUM COMPUTATION

	Principal Applicant	Dependent 1	Dependent 1
First Name:	_____	_____	_____
Critical Illness Sum Insured (Please check box and write corresponding premium based on age, plan and Sum Insured chosen.)			
$ 25,000	☐ _____	☐ _____	☐ _____
$ 50,000	☐ _____	☐ _____	☐ _____

GRAND TOTAL ⟶ _____

Important Notice: This application form is subject to medical evaluation. Premium loading may be applied subject to the results of the medical evaluation. Premiums are inclusive of all applicable taxes.

PAYMENT OPTIONS

TERMS and MODE OF PAYMENT (Same as the Core Benefit):

☐ Annual
☐ (PhP ☐ USD _____)

☐ Semi-Annual (with 8% surcharge)
(Annual Premium x 0.54 = ☐ PhP ☐ USD _____

NOTES:

CONTACT US

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You may request additional copies of this application form from our Medical Sales Representatives.