

**CRITICAL COVER EXTRA**

Critical Illness Insurance Rider

**APPLICATION FORM**

|  |
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| **Directions:** Please answer this application form as truthfully as possible. All sections must be completely filled out. To maintain the integrity of your answers, please convert the file to PDF or “Read Only” before submitting the application form. Soft copies will temporarily be accepted to process evaluation. Please safekeep the electronic file. Please note that you will still be asked to submit a duly signed and dated print-out of this form. This form is valid for 45 days from the date of your application.  |

**PERSONAL INFORMATION: Principal Applicant**

|  |  |
| --- | --- |
| **FIRST NAME:** |       |
| **MIDDLE NAME:** |       | **LAST NAME:** |       |
| **MOTHER’S MAIDEN NAME:** |       |
| **BIRTHDATE** (mm/dd/yyyy)**:** |       | **PLACE OF BIRTH:** |       |
| **NATIONALITY:** |       | **CIVIL STATUS:** | [ ]  Single [ ]  Married [ ]  Widow/Widower [ ]  Separated |
| **SEX:** | [ ]  Male [ ]  Female | **WEIGHT** (lbs.)**:** |       | **HEIGHT** (ft. & in.)**:** |       |
| **OCCUPATION:** |       |
| **FAMILY DOCTOR NAME:** |       | **CLINIC/HOSPITAL ADDRESS:** |       |
| **TEL. NO.:** |       | **FAX NO.:** |       | **E-MAIL ADDRESS:** |       |

**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).

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| **DEPENDENT 1 (i.e., Spouse)** |
| **FIRST NAME:** |       |
| **MIDDLE NAME:** |       | **LAST NAME:** |       |
| **BIRTHDATE** (mm/dd/yyyy)**:** |       | **BIRTHPLACE:** |       |
| **SEX:** | [ ]  Male [ ]  Female | **NATIONALITY:** |       | **WEIGHT** (lbs.)**:** |       | **HEIGHT** (ft. & in.)**:** |       |
| **OCCUPATION:** |       |

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| **DEPENDENT 2** |
| **FIRST NAME:** |       |
| **MIDDLE NAME:** |       | **LAST NAME:** |       |
| **BIRTHDATE** (mm/dd/yyyy)**:** |            | **BIRTHPLACE:** |       |
| **SEX:** | [ ]  Male [ ]  Female | **NATIONALITY:** |       | **WEIGHT** (lbs.)**:** |       | **HEIGHT** (ft. & in.)**:** |       |
| **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**

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| --- |
| Directions: Please identify your Household Annual Salary range: |
|  |  |  |
| [ ]  PHP 300,000 and below | [ ]  PHP 500,001 and PHP 700,000 | [ ]  PHP 1,000,001 and PHP 1,500,000 |
| [ ]  PHP 300,001 and PHP 500,000 | [ ]  PHP 700,001 and PHP 1,000,000 | [ ]  Above PHP 1,500,000 |

**MEDICAL QUESTIONNAIRE**

|  |  |  |  |
| --- | --- | --- | --- |
| **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?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. 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.
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Any chest or breathing complaint?

e.g., asthma, bronchitis, tuberculosis, persistent hoarseness or cough, or other respiratory problems  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Any complaint of the digestive system?

e.g., hepatitis or hepatitis carrier, gallstones, gastric ulcer, esophageal reflux, polyps, bowel or rectal bleeding  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. 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.  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. 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.
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Any endocrine disorders?e.g., diabetes, pituitary disorder, thyroid disorder
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. 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?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Cancer, tumor, lumps, cyst, disorder of skin, disorder of lymph gland, anemia, leukemia, other disorder of blood?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Have you been tested for HIV-antibodies?

If yes, what was the result?  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| [ ]  HIV-Positive | [ ]  HIV-Positive | [ ]  HIV-Positive |
| [ ]  HIV-Negative | [ ]  HIV-Negative | [ ]  HIV-Negative |
| 1. 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 5.)
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Have you ever received medical advice or counseling in connection with hepatitis, HIV/AIDS or any sexually transmitted conditions?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. 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 5.)
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Are you planning a medical consultation or treatment? (If yes, please state your reason on the space provided on page 5.)
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Have you ever been, or are you currently a smoker?
	1. If yes, for how long?
	2. If still a smoker, how many cigarette sticks per day?
	3. If you have stopped smoking, please state the date and reason.
	4. Did you receive medical advice to stop smoking? (If yes, please state the reason on the space provided on page 5.)
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|       years |       years |       years |
|       cig. sticks |       cig. sticks |       cig. sticks |
| Date:      Reason:       | Date:      Reason:       | Date:      Reason:       |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Do you drink alcohol or ever regularly drink alcohol? If yes,
	1. Please state type (spirits, wine, beer, etc.).
	2. Please state quantity (centiliter, units, glasses, bottles, etc.) per week.
	3. If you have stopped drinking, please state the date and reason.
	4. Did you receive medical advice to stop drinking? (If yes, please state the reason on the space provided on page 5.)
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|       |       |       |
|       |       |       |
| Date:      Reason:       | Date:      Reason:       | Date:      Reason:       |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Have you ever used any habit-forming drugs or narcotics? (If yes, please give details on the space provided on page 5.)
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. 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 5.)
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Have your natural parents or siblings had any of the following illnesses?
	1. Diabetes
	2. Cancer(s)

b1. Breast b2. Cervicalb3. Ovarianb4. Colonb5. Other Cancer(s) * 1. High blood pressure
	2. Heart problems
	3. Stroke
	4. Haemochromatosis
	5. Huntington disease (Huntington’s Chorea)
	6. Polycystic kidney disease
	7. Multiple sclerosis
	8. Mental disease
	9. 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 6.  | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  |
| 1. 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 5.)
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. 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 provide details on the space provided on page 5.)
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Insurance application/policy
 |  |  |  |  |  |  |
| * 1. Has any of your medical, critical illness or life application been declined, rated or restricted?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * 1. Do you have any existing or pending application for Critical Illness coverage other than this application?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| * 1. 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 6.)  |  |  |  |  |  |  |
| 1. Do you engage in any form of sports?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| If yes, specify. |       |       |       |
| **NOTE: Question numbers 15 to 17 are to be completed by Female Applicants only.** |  |  |  |  |  |  |
| 1. 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 5.)
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Are you now pregnant?
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| If yes, please state month(s) of pregnancy. |       mos. |       mos. |       mos. |
| 1. 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 5.)
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |

**DETAILS OF YES RESPONSES**

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| --- |
| **If space is insufficient, please attach additional details.**  |
| **Qstn No.** | **Medical** **Condition** | **Nature/Date** **of Treatment** | **Current** **Status** | **Doctor’s** **Name** | **Doctor’s Current Info (Address, Phone No., Fax No.)** |
| **Name of Principal Applicant:**  |       |
|       |       |       |       |       |       |
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| **Additional pages attached?**  | **Remarks (for Pacific Cross use only):** |
| [ ]  YES  | [ ]  NO  |       |
| **Name of Dependent 1:** |       |
|       |       |       |       |       |       |
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| **Additional pages attached?**  | **Remarks (for Pacific Cross use only):** |
| [ ]  YES  | [ ]  NO  |       |
| **Name of Dependent 2:** |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
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| **Additional pages attached?** | **Remarks (for Pacific Cross use only):** |
| [ ]  YES  | [ ]  NO  |       |

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| **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?**  | **Remarks (for Pacific Cross use only):** |
| [ ]  YES  | [ ]  NO  |       |
| **Name of Dependent 1:** |       |
|       |       |       |
|       |       |       |
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| **Additional pages attached?**  | **Remarks (for Pacific Cross use only):** |
| [ ]  YES  | [ ]  NO  |       |
| **Name of Dependent 2:** |       |
|       |       |       |
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|       |       |       |
| **Additional pages attached?** | **Remarks (for Pacific Cross use only):** |
| [ ]  YES  | [ ]  NO  |       |

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| **For Medical Questionnaire Item No. 11 (Other Insurance Applications or Policies), please provide details below.**  |
| **Relationship to Applicant (e.g., 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:**  |       |
|       |       |       |       |       |       |
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| **Additional pages attached?**  | **Remarks (for Pacific Cross use only):** |
| [ ]  YES  | [ ]  NO  |       |
| **Name of Dependent 1:** |       |
|       |       |       |       |       |       |
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| **Additional pages attached?**  | **Remarks (for Pacific Cross use only):** |
| [ ]  YES  | [ ]  NO  |       |
| **Name of Dependent 2:** |       |
|       |       |       |       |       |       |
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| **Additional pages attached?** | **Remarks (for Pacific Cross use only):** |
| [ ]  YES  | [ ]  NO  |       |

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| **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:**  |       |
|       |       |       |       |       |
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| **Additional pages attached?**  | **Remarks (for Pacific Cross use only):** |
| [ ]  YES  | [ ]  NO  |       |
| **Name of Dependent 1:** |       |
|       |       |       |       |       |
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| **Additional pages attached?**  | **Remarks (for Pacific Cross use only):** |
| [ ]  YES  | [ ]  NO  |       |
| **Name of Dependent 2:** |       |
|       |       |       |       |       |
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| **Additional pages attached?** | **Remarks (for Pacific Cross use only):** |
| [ ]  YES  | [ ]  NO  |       |

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 all the applicable insured’s benefits under the plan. I also understand that this application may be returned to me if I fail to complete all details requested.

I understand that this application form and all test results are subject to medical evaluation. I understand that a premium loading may be applied subject to the results of the medical evaluation. I understand that Pacific Cross Insurance, Inc. reserves the right to decline application for coverage based on the results of the medical evaluation.

I certify that I am informed of the benefits, exclusions and all other provisions of the Policy.

I certify that I am informed and have understood the meaning of **PRE-EXISTING CONDITIONS** and **MEDICAL EXCLUSIONS**.

* Pre-Existing Conditions are conditions which are not covered on the first year of the Policy. On the second year and every year thereafter, utilization related to Pre-Existing Conditions will be covered only upon payment of additional premium as determined by Pacific Cross.
* Medical Exclusions are medical conditions which are permanently excluded from my medical coverage. As such, entitlement to any benefit arising from such conditions will not be covered at any time under the Policy.

I further acknowledge that I am aware that should there be any concerns on the representations that were made to me, I will immediately contact Pacific Cross through the fraud reporting link on the Pacific Cross website ([www.pacificcross.com.ph](http://www.pacificcross.com.ph)).
 I hereby authorize Pacific Cross Insurance, Inc. and/or Pacific Cross Health Care, Inc. and all persons duly authorized and acting on their behalf to request and receive any information or document and 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, and such other matters related thereto. A photocopy of this authorization is considered an original for all intents and purposes.

I understand that under Republic Act 9160 (Anti-Money Laundering Act) as amended by Republic Act 9194 and pertinent regulations, all insurance companies are required to satisfactorily establish the identities of all its customers. Hence, Pacific Cross Insurance, Inc. reserves the right not to accept and process any application for insurance if the customer fails to provide sufficient evidence to establish his identity.

I declare that I have read all particulars stated on all pages of this form and I hereby represent and confirm that the statements, answers and details indicated herein are true, complete and correct, were written by me or by someone else upon my expressed instructions and shall be binding on me.

I understand that the receipt of payment by Pacific Cross does not constitute acceptance of my application or of my dependents until the corresponding application has been approved and the membership card/s has been issued to me or my dependents.

**DATA PRIVACY CONSENT:** I understand that Pacific Cross collects and uses my personal information in order to service and administer the insurance policy and provide appropriate and timely Medical services. By signing this application form and all other forms attached to it, I agree that these information may be processed, shared, disclosed, transferred or used by Pacific Cross in accordance with the Data Privacy Act of 2012, its implementing rules and regulations, and the Pacific Cross Privacy Statement attached to this Application Form (a copy of the Pacific Cross Privacy Statement is also available at www.pacificcross.com.ph). 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 information.

**POLICYHOLDERS’ BILL OF RIGHTS:** (1) Right to a financially sound and viable insurance company; (2) Right to access insurance companies’ official financial information; (3) Right to be informed of the license status of insurance companies, intermediaries and soliciting agents; (4) Right to be offered a duly approved insurance product; (5) Right to be informed of the benefits, exclusions and other provisions under the policy; (6) Right to receive the policy; (7) Right to confidentiality of information; (8) Right to efficient service from insurance companies, intermediaries and soliciting agents; (9) Right to prompt and fair settlement of claims; (10) Right to seek assistance from the Insurance Commission.

|  |  |
| --- | --- |
| **Name of Principal Applicant:** |       |

|  |  |
| --- | --- |
| **Signature of Principal Applicant:** |  |

|  |  |
| --- | --- |
| **If the insured is a minor, name of Applicant – payor** (e.g., parent or guardian)**:** |       |

|  |  |
| --- | --- |
| **Signature of Applicant – payor:** |  |

|  |  |
| --- | --- |
| **Date** (mm/dd/yyyy)**:** |       |

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| --- |
| **PREMIUM COMPUTATION** |
|  | **Principal Applicant** | **Dependent 1** | **Dependent 2** |
| First Name |       |       |       |
| **Critical Illness Sum Insured (Please check box & write corresponding premium based on age, plan and option chosen.)** |
| $ 25,000 | [ ]        | [ ]        | [ ]        |
| $ 50,000 | [ ]        | [ ]        | [ ]        |
| **GRAND TOTAL** |  |  |  | [ ]  ₱ [ ]  $       |
|  |  |  |  |  |
| **IMPORTANT NOTE:** This application form is subject to medical evaluation. Premium loading for Take-Over applications and succeeding renewals may be applied subject to the results of the medical evaluation. Premiums are inclusive of all applicable taxes.  |

**PAYMENT OPTIONS**

|  |  |  |
| --- | --- | --- |
| **TERMS OF PAYMENT:** | [ ]  Annual | [ ]  Semi-Annual (8% surcharge will apply) |
|  |  ( [ ]  ₱ [ ]  $       ) |  ( [ ]  ₱ [ ]  $       ) |
| **NOTES:** |       |

**CONTACT US**



**HEAD OFFICE**

2nd Floor (Client & Partner Center), 8th Floor (Sales & Customer Service Center)

and 18th Floor (Operations & Executive Center),

8 Rockwell Building, Hidalgo Drive, Makati City, Metro Manila, Philippines

Tel. No.: +63 2 8230-8511 Fax No.: +63 2 8325-0638

E-mail: info@pacificcross.com.ph

**PROVINCIAL BRANCHES**

**CEBU**

Unit 201-202, Avagar Building, No. 09, Escario corner Molave Streets, Lahug, Cebu City, Philippines

Tel. Nos.: +63 32 233-5812, +63 32 233-5816, +63 32 416-4468 Fax No.: +63 32 233-5814

E-mail: cebu@pacificcross.com.ph

**CLARK**

2nd Floor, Room 217, The Medical City Clark, 100 Gatwick Gateway,

Clark Global City, Clark Freeport Zone, Pampanga, 2023, Philippines

Mobile No.: +63 914 894-9211

E-mail: clark@pacificcross.com.ph

**DAVAO**

2nd Floor, Left Wing, Door No. 6, Matina Town Square, Mac Arthur Highway, Matina, Davao City, Philippines

Tel. No.: +63 82 297-7314 Telefax: +63 82 297-7151

E-mail: davao@pacificcross.com.ph

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

Application forms are also available on our website for download.