

Pacific Cross Insurance, Inc.



☐ BR Plan A

BR Plan B

BR Plan C

INSURANCE TYPE: ☐ Individual ☐ Family

2 x 2 photo
of Principal
Applicant

[illegible][illegible]

BIRTHDATE: PLACE OF BIRTH: NATIONALITY:
month day year

CIVIL STATUS: ☐ Single ☐ Married ☐ Widow/Widower ☐ Separated SEX: ☐ Male ☐ Female WEIGHT: lbs. HEIGHT: ft in

OCCUPATION: NATURE OF WORK (Administration, Sales, etc.):

NAME OF EMPLOYER: If self-employed, nature of business:

SOURCES OF FUNDS OR PROPERTY: ☐ Salary ☐ Business ☐ Others (Pls. specify: _____)

GOV'T ISSUED CARD: ☐ Passport ☐ TIN ☐ SSS ☐ GSIS ☐ Driver's License ☐ Others (Pls. specify: _____) No.: _____

Are you and/or your immediate family member (within the second degree of consanguinity or affinity) entrusted with appointive or elective position in the Philippines or in a foreign state, a senior politician, judicial or military official, senior executive of government or state-owned or controlled corporations or political party official? ☐ No ☐ Yes (Name/Position/Public Office: _____)

	Name	Birthdate (mm/dd/yyyy)	Relationship to Principal Applicant
BENEFICIARY:			

PLACE OF BIRTH: CONTACT NUMBER: SEX: ☐ Male ☐ Female NATIONALITY:

ADDRESS:

GOV'T ISSUED CARD: ☐ Passport ☐ TIN ☐ SSS ☐ GSIS ☐ Driver's License ☐ Others (Pls. specify: _____) No.: _____

PERMANENT ADDRESS (Home Country)

(Number, Street, Block, Subdivision, City, Zip Code, Province, Country)

PRESENT ADDRESS (Country of Residence*):

RESIDENCE (Number, Street, Block, Subdivision, City, Zip Code, Province, Country)**BUSINESS** (Number, Street, Block, Subdivision, City, Zip Code, Province, Country)

**Must be the Insured's place of residence or place of employment for not less than 6 months within the Period of Insurance. It is deemed to be the Philippines unless otherwise declared and covered by an Endorsement to the Policy.*

E-MAIL ADDRESS:

**This e-mail address will be used for sending your policy documents which may include sensitive medical information. Your membership card and all policy documents will be sent to you by e-mail.*

CONTACT DETAILS:Residence Tel. No.: Business Tel. No.: Fax No.:

Mobile No.: Alternate Mobile No.: Alternate E-mail Address:

For Internal Use Only

SELLER'S DETAILS

Date Received: _____

☐ TIED AGENTS (AE's ID No.: _____) ☐ INTERMEDIARY If Broker, name of Company: _____

If Broker, name of Company:

If Agent, name of Agent: _____

Broker/Agent Code: _____

PRODUCT and PLAN DETAILS

Effectivity Date: (mm/dd/yyyy)

REMARKS:

☐ New Applicant ☐ Additional Applicant ☐ Re-Application ☐ Take-Over Account ☐ Transferee

State insurance company/HMO (If a Take-Over Account):

DEPENDENTS TO BE INSURED

For Single Applicant - Please state names of parents first, followed by siblings (from eldest to youngest). **For Married Applicant** - Please state name of spouse first, followed by children (from eldest to youngest). **If there are more than three (3) dependents, please use additional copies of this form.**

DEPENDENT 1 (i.e., Spouse or Parent)		Relationship to Principal Applicant:	
FIRST NAME:		MIDDLE NAME:	
LAST NAME:		BIRTHPLACE:	
PRESENT ADDRESS: (if different from Principal Applicant)			
E-MAIL ADDRESS:	RESIDENCE TEL. NO.:	MOBILE NO.:	BIRTHDATE: mm/dd/yyyy
SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	NATIONALITY:	WEIGHT: lbs.	HEIGHT: feet inches
GOV'T ISSUED CARD: <input type="checkbox"/> Passport <input type="checkbox"/> TIN <input type="checkbox"/> SSS <input type="checkbox"/> GSIS <input type="checkbox"/> Driver's License <input type="checkbox"/> Others (Pls. specify:)		No.:	
OCCUPATION:	NATURE OF WORK (Administration, Sales, etc.):		
NAME OF EMPLOYER: (if applicable)	If self-employed, type of industry:		
Name		Date of Birth (mm/dd/yyyy)	Relationship to Dependent 1
BENEFICIARY:		Place of Birth	Contact Number
ADDRESS:		SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	NATIONALITY:
GOV'T ISSUED CARD: <input type="checkbox"/> Passport <input type="checkbox"/> TIN <input type="checkbox"/> SSS <input type="checkbox"/> GSIS <input type="checkbox"/> Driver's License <input type="checkbox"/> Others (Pls. specify:)		No.:	

DEPENDENT 2		Relationship to Principal Applicant:	
FIRST NAME:		MIDDLE NAME:	
LAST NAME:		BIRTHPLACE:	
PRESENT ADDRESS: (if different from Principal Applicant)			
E-MAIL ADDRESS:	RESIDENCE TEL. NO.:	MOBILE NO.:	BIRTHDATE: mm/dd/yyyy
SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	NATIONALITY:	WEIGHT: lbs.	HEIGHT: feet inches
GOV'T ISSUED CARD: <input type="checkbox"/> Passport <input type="checkbox"/> TIN <input type="checkbox"/> SSS <input type="checkbox"/> GSIS <input type="checkbox"/> Driver's License <input type="checkbox"/> Others (Pls. specify:)		No.:	
OCCUPATION:	NATURE OF WORK (Administration, Sales, etc.):		
NAME OF EMPLOYER: (if applicable)	If self-employed, type of industry:		
Name		Date of Birth (mm/dd/yyyy)	Relationship to Dependent 2
BENEFICIARY:		Place of Birth	Contact Number
ADDRESS:		SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	NATIONALITY:
GOV'T ISSUED CARD: <input type="checkbox"/> Passport <input type="checkbox"/> TIN <input type="checkbox"/> SSS <input type="checkbox"/> GSIS <input type="checkbox"/> Driver's License <input type="checkbox"/> Others (Pls. specify:)		No.:	

DEPENDENT 3		Relationship to Principal Applicant:	
FIRST NAME:		MIDDLE NAME:	
LAST NAME:		BIRTHPLACE:	
PRESENT ADDRESS: (if different from Principal Applicant)			
E-MAIL ADDRESS:	RESIDENCE TEL. NO.:	MOBILE NO.:	BIRTHDATE: mm/dd/yyyy
SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	NATIONALITY:	WEIGHT: lbs.	HEIGHT: feet inches
GOV'T ISSUED CARD: <input type="checkbox"/> Passport <input type="checkbox"/> TIN <input type="checkbox"/> SSS <input type="checkbox"/> GSIS <input type="checkbox"/> Driver's License <input type="checkbox"/> Others (Pls. specify:)		No.:	
OCCUPATION:	NATURE OF WORK (Administration, Sales, etc.):		
NAME OF EMPLOYER: (if applicable)	If self-employed, type of industry:		
Name		Date of Birth (mm/dd/yyyy)	Relationship to Dependent 3
BENEFICIARY:		Place of Birth	Contact Number
ADDRESS:		SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	NATIONALITY:
GOV'T ISSUED CARD: <input type="checkbox"/> Passport <input type="checkbox"/> TIN <input type="checkbox"/> SSS <input type="checkbox"/> GSIS <input type="checkbox"/> Driver's License <input type="checkbox"/> Others (Pls. specify:)		No.:	

MEDICAL QUESTIONNAIRE *Page 3 of 6 (Blue Royale Medical Plan Application Form)*

[illegible]

DETAILS OF YES RESPONSES

If space is insufficient, you may use additional sheets of paper with your signature. To ensure that sufficient information is received for our timely and complete assessment, each item containing the details of YES responses must be supported with the corresponding medical reports to be submitted together with this application form.

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:					
Attachments: <input type="checkbox"/> Medical test results <input type="checkbox"/> Utilization/claims report <input type="checkbox"/> Medical certificate <input type="checkbox"/> Others: _____			Remarks:		
Name of Dependent 1:					
Attachments: <input type="checkbox"/> Medical test results <input type="checkbox"/> Utilization/claims report <input type="checkbox"/> Medical certificate <input type="checkbox"/> Others: _____			Remarks:		
Name of Dependent 2:					
Attachments: <input type="checkbox"/> Medical test results <input type="checkbox"/> Utilization/claims report <input type="checkbox"/> Medical certificate <input type="checkbox"/> Others: _____			Remarks:		
Name of Dependent 3:					
Attachments: <input type="checkbox"/> Medical test results <input type="checkbox"/> Utilization/claims report <input type="checkbox"/> Medical certificate <input type="checkbox"/> Others: _____			Remarks:		

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 declared to the Company and have been included by an Endorsement are covered according to the terms specified therein. It shall only be covered provided that there is no failure to disclose, misrepresent or conceal material information. Every year upon renewal, utilization related to Pre-Existing Conditions will be covered 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).

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.

During the effectivity of the Policy, the Policyholder agrees to the following:

- In case the Company is unable to comply with relevant customer due diligence (CDD) measures, as required under the Anti- Money Laundering Act, as amended and relevant issuances, due to the fault of the Policyholder, the Company may apply the following:
 - Measures to restrict the services available or prohibit any further transactions on the Policyholder until full and proper CDD measures have been successfully conducted; and
 - In case the foregoing is unsuccessful, terminate business relationship. The exercise of the Company of this measure shall only entitle the Policyholder to receive the unused portions of premium or withdrawal value, if any, whichever is applicable.
- Be bound by obligations set out in relevant United Nations Security Council Resolutions relating to the prevention and suppression of proliferation financing of weapons of mass destruction, including the freezing and unfreezing actions as well as prohibitions from conducting transactions with designated persons and entities.

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 Policy has been issued to me or my dependents.

I understand that the Policy and related Notices may be sent to me through e-mail, SMS or by mail based on the contact information I provided above.

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.

NOTED BY:

Signature over printed name of Principal Applicant:	Signature over printed name of Spouse:	I ensure that I, as the agent/AE/broker, have guided the Policyholder in completing all relevant and necessary information to assist the Company in assessing the application. I further declare that: 1. The information provided by the Policyholder in the application form are accurate and complete; 2. I/we also certify that I/we saw the Proposed Insured and have verified the information in this application against the original ID card/s presented and in doing so, have established the identity at the time of signing this application; 3. I shall make known to the Company any and all factors which, if known to the Company, may result in an applicant receiving rated or no coverage at all; and 4. Any additional information that shall be required by the Company in order to determine any particular application shall be provided on a timely basis.	
Signature over printed name of Legal Age Dependent:	If the insured is a minor, signature over printed name of Applicant - payor (e.g., parent or guardian):	Signature over printed name of Account Executive/Broker/Agent	
Date: Month Day Year	Place of signing:	Date: Month Day Year	If Broker/Agent, please indicate agent's code:

PREMIUM COMPUTATION

	Principal Applicant	Dependent 1	Dependent 2	Dependent 3
First Name	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>

CORE BENEFITS (Please check box and write corresponding premium based on age, plan and option chosen.)

Blue Royale

Plan A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others: <input style="width: 150px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A Subtotal Core Benefits Premium

<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
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OPTIONAL BENEFITS (Please check box and write additional premium based on age, plan and option chosen.)

Dental - \$2,000 Annual Limit (Plans A & B only; Dental already included in Plan C)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Vision (Available only for groups of 21+ who all opt for the same benefit. Vision already included in Plan C, \$500 Annual Limit)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Personal Accident Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Others: <input style="width: 150px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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B Subtotal Optional Benefits Premium

<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
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DISCOUNT OPTIONS (Please check box and calculate applicable discounts.) Note: Discount options are only applied to medical core benefits premium.

C = A - \$4.00 DST Amount

<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
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D Deductible Discount = C x % discount

Blue Royale

\$1,000 deductible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15% discount (Plan A only)				
\$2,500 deductible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30% discount (Plan A)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18% discount (Plan B)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18% discount (Plan C)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
\$5,000 deductible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40% discount (Plan A)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24% discount (Plan B)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24% discount (Plan C)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E Treatment Area Limitation Discount = (C - D) x % discount (By choosing the TAL option, I confirm that I understand the contract provisions related to Treatment Area Limitation, and that it was properly explained to me by my Agent).

BR (25% discount)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others: <input style="width: 150px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F Total Amount of Applicable Discount

<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
--	--	--	--

ANNUAL PREMIUM = A + B - F (Core Benefits Premium + Optional Benefits Premium - Total Amount of Applicable Discounts)

Annual Premium (per person)	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
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GRAND TOTAL

☐ ₱ ☐ \$

IMPORTANT NOTE:

This application form is subject to medical evaluation. Premium loading for New Business, Take-Over applications and succeeding renewals may be applied subject to the results of the medical evaluation. Premiums are inclusive of all applicable taxes.

TERMS OF PAYMENT: ☐ Annual ☐ Semi-Annual (8% surcharge and DST charge will apply)
(☐ ₱ ☐ \$ _____) (☐ ₱ ☐ \$ _____)

MODE OF PAYMENT: ☐ Cash
☐ Check (Please make check payable to Pacific Cross Insurance, Inc.)
☐ Bills Payment ☐ BDO ☐ Metrobank
☐ Credit Card (Please fill out a Credit Card Payment Authorization form. You may request from our Medical Sales Representatives, or download a copy from our website.)
☐ Web Payment - Pacific Cross's online payment gateway through www.pacificcross.com.ph accepts the following:

- Credit/Debit Cards
- Gcash
- Maya
- Over-the-counter (7/11 OTC, Cliqq OTC, DA5 OTC and DragonPay OTC)

PHOTOS: Dependents

2 x 2 photo
of Dependent 1

2 x 2 photo
of Dependent 2

2 x 2 photo
of Dependent 3

CONTACT US



HEAD OFFICE

2nd Floor (Client & Partner Center), 8th Floor and 18th Floors, 8 Rockwell Building, Hidalgo Drive, Makati City, Metro Manila, Philippines
Tel. No.: +63 2 8230-8511 Fax No.: +63 2 8230-8572
E-mail: info@pacificcross.com.ph

PROVINCIAL OFFICES

CEBU

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CLARK

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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

We also have Agency Offices in:

Luzon: Cavite | Makati | Manila | Marikina | Muntinlupa | Naga | Novaliches | Pampanga
VisMin: Bacolod | Butuan | Cagayan de Oro | Davao | Dumaguete | General Santos

Visit www.pacificcross.com.ph for more information.

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