BLUE ROYALE MEDICAL PLAN APPLICATION FORM



Pacific Cross Insurance, Inc.

Application Reference No.:	BR Plan A BR Plan B BR Plan C
Directions: Please answer this application form as truthfully as possible. All sections m ballpen or signpen. Please use block letters. Application forms without the appropriate be returned. This form is valid for 45 days from the date of your application.	
INSURANCE TYPE: Individual Family	
PERSONAL INFORMATION: Principal Applicant	2 x 2 photo
FIRST NAME:	of Principal Applicant
MIDDLE NAME: LAST NAME:	, Applicant
MOTHER'S MAIDEN NAME:	
BIRTHDATE: PLACE OF BIRTH: NAT	TIONALITY:
CIVIL STATUS: Single Married Widow/Widower Separated SE	X: Male Female WEIGHT: lbs. HEIGHT: ft in
OCCUPATION: NATURE OF WORK (Ad	ministration, Sales, etc.):
NAME OF EMPLOYER: If self-e	employed, nature of business:
SOURCES OF FUNDS OR PROPERTY: Salary Business	Others (Pls. specify:)
GOV'T ISSUED CARD: Passport TIN SSS GSIS Driver's Lie	cense Others (Pls. specify:) No.:
Are you and/or your immediate family member (within the second degree of consanguinity or affinite entrusted with appointive or elective position in the Philippines or in a foreign state, a senior politicial judicial or military official, senior executive of government or state-owned or controlled corporations of political party official?	No Yes (Name/Position/Public Office:
Name BENEFICIARY:	Birthdate (mm/dd/yyyy) Relationship to Principal Applicant
PLACE OF BIRTH: CONTACT NUMBER:	SEX: Male Female NATIONALITY:
ADDRESS:	
GOV'T ISSUED CARD: Passport TIN SSS GSIS Driver's Lie	cense Others (Pls. specify:) No.:
CONTACT INFORMATION	_
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)	ce, Country)
BUSINESS (Number, Street, Block, Subdivision, City, Zip Code, Province	e, Country)
*Must be the Insured's place of residence or place of employment for not less than 6 mo otherwise declared and covered by an Endorsement to the Policy.	onths within the Period of Insurance. It is deemed to be the Philippines unless
E-MAIL ADDRESS:	
*This e-mail address will be used for sending your policy documents which may include sensitive medical in CONTACT DETAILS:	formation. Your membership card and all policy documents will be sent to you by e-mail.
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 Agent, name of Agent:
PRODUCT and PLAN DETAILS	Broker/Agent Code:
Effectivity Date: (mm/dd/yyyy)	REMARKS:
New Applicant Additional Applicant Re-Application Tak	
State insurance company/HMO (If a Take-Over Account):	_

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.

FIRST NAME:	DEPENDENT 1 (i.e., Spouse or Parent) Relationship to Principal Applicant:
PRESENT ADDRESS: PARTICIPATION: MOBILE NO: BIRTHDATE: MIRCHARD	FIRST NAME: MIDDLE NAME:
Contact Number Cont	LAST NAME: BIRTHPLACE:
SEX: Male Female NATIONALITY: WEIGHT: Ibs. HEIGHT: Feet inches GOV'T ISSUED CARD: Passport TIN SSS GSIS Driver's License Others (Pk. specify:) No.: OCCUPATION: NATURE OF WORK (Administration, Sales, etc.): NAME OF EMPLOYER: If self-employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry: (if applicable) Name Date of Birth (employed, type of industry:	
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ADDRESS: SEX: Male Female NATIONALITY:	Name Date of Birth (mm/dd/yyyy) Place of Birth Relationship to Dependent 3 Contact Number
ADDITION.	OSY DAAL DE L MATIONAUTY
	ADDITION.

DIRECTIONS: Please tick YES or NO to every question for each person to be insured.		First Name of Applicant Dependent 1		First Name of Dependent 2		First Name of Dependent 3		
	YES	NO	YES	NO	YES	NO	YES	NO
1. Are you currently covered under PhilHealth?								
2. a. Are you currently covered by any medical policy?				$\overline{}$				
(Please include a copy of the policy and benefit schedule.)								
b . Has any of your medical or life application been declined, rated or restricted?								
c. Has any of your medical or life policy been cancelled, withdrawn, rated or								
restricted?								
3. Have you ever been, or are you currently a smoker? If YES:	U				U .	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	│ 凵 .	
a. How long have you been a smoker?		ears g. sticks		years cig. sticks		ears ig. sticks	}	ears ig. sticks
b. If still a smoker, how many cigarette sticks per day?		ears	I	years		ears		ears
c. If no longer a smoker, provide no. of years since you last smoked.				7				
4. Do you engage in any form of sports? Please specify.	l							
If you tick YES to any of the questions, please provide DETAILS OF YES RESPONSES at Please ensure that you tell us about all your medical conditions and symptoms, when professional advice was sought. If you were previously or already are a Pacific Cross F as a new business under any Pacific Cross products, please include details of any cor	nether pa Policyholo	st and/or der and ye	present, ou are ap	, known plying to	and/or su increase	uspected, cover or	, whethe you are a	r or not pplying
5. At any given time, have you had symptoms of or been diagnosed or treated								
for any:						_		
a. speech defect, paralysis, hearing loss, physical or birth defect, infirmity,								
congenital/hereditary illness or chronic condition?								
b. ear discharge, nose bleeds, double vision, impaired sight, respiratory or								
allergic condition or disorder of the eye, ear, nose or throat?								
c. mental disorder (disease of the brain), nervous disorder, stroke, seizure or fit,								
weakness, swelling or dislocation of a limb, prolonged headache, blackout,	_	_	_	_	_	_	_	
fainting, mood change, sleep disorder/insomnia, drug/alcohol addiction?								
d. blood pressure problem, chest pain, cholesterol problem, dizziness,								
anemia, heart murmur, breathlessness, abnormal heart rate, rheumatic	_	_	_	_	_			
fever, varicose veins, heart or circulatory disorder? e. jaundice, hepatitis of any form, gall/kidney stone, venereal disease, or disorder								
of the bladder/urination, prostate, kidney, genitourinary tract or pancreas?				ш				
f. Indigestion, gastritis, ulcer, blood in stools, fistula, hernia, hemorrhoid,								
colitis or stomach, liver or bowel disorders?								
g. back or neck pain or strain, spinal condition, sciatica, slipped disc, whiplash,								
gout, bone fracture, joint pain or joint injury (e.g., knee, elbow, wrist,								
shoulder), hallux valgus (hammer toes), muscle disorder, arthritis, joint								ш
or bone disease?								
h. HIV, AIDS/AIDS Related Complex or any indication of blood or immune								
system connective tissue disorder?				_				_
i. any form of cancer, mass, lump, cyst, tumor or growth of any kind?								
j. psoriasis, eczema, dermatitis, acne or any other skin condition?		一一		一一		$\overline{}$		$\overline{}$
k. hormone, endocrine or glandular disorder or condition like:								
k1. diabetes								ᆜ
k2. thyroid (ex: goiter)/parathyroid disorder				닏				닠
k3. obesity						닏		닉
k4. endocrine tumors		님						님
k5. others (Please specify)?								
I. (for females only) complications of pregnancy, pregnancy-related disease,								
abnormal smear test or any gynecological/menopausal disorder (e.g.,								
fibroid) and/or cyst of the female reproductive system?								
6. Have you ever been prescribed or recommended, underwent, or are currently taking								
any medication or treatment? (Please list dosage and other details on next page.)								
7. Have you been a patient (as out-patient or in-patient) in a hospital, clinic or								
sanitarium at any given time?								
8. Have you undergone or been advised to have any medical test or procedure								
other than as noted above? (Please provide details on next page.)								
9. Is there any accident, injury, illness, disease, condition, ailment, impairment,							📙	
medical investigations, or hospital treatments not mentioned above?								
10. Are there additional pages forming part of your declarations that are attached to this Application Form?							📙	
LO LINS ADDIICALION FORMS			1				1	

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 Medical No. Condition	Nature/Date of Treatment	Current Status	Doctor's Name	Doctor's Current Info (Address, Phone No., Fax No.)
Name of Principal Applicant:				
Attachments:		Remarks:		
	on/claims report			
,				
Name of Dependent 1:				
Attachments:		Remarks:		
1 11000 011111011001	on/claims report	Remarks:		
Name of Dependent 2:				
Attachments:		Remarks:		
	on/claims report	Kelliai KS.		
☐ Medical certificate ☐ Others:	·			
Name of Dependent 3:				
Attachments:		Remarks:		
	on/claims report			
☐ Medical certificate ☐ Others:				

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:

- 1. 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
 - b. 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.
- 2. 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.

Signature over printed Signature over name of Principal printed name of Applicant: Spouse: Signature over printed If the insured is a minor, signature name of Legal Age over printed name of Applicant -Dependent: payor (e.g., parent or guardian): Date: Place of signing: Month Dav Year

NOTED BY:

- 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 Account Executive/Broker/Agent Date: If Broker/Agent, please Month indicate agent's code:

	I KEMIOI	M COMPUTATION		
	Principal Applicant	Dependent 1	Dependent 2	Dependent 3
First Name				
CORE BENEFITS (Please check box	and write corresponding	premium based on age,	plan and option chosen	n.)
Blue Royale Plan A Plan B Plan C Others:				
Subtotal Core Benefits Premium				
OPTIONAL BENEFITS (Please checl	box and write additiona	l premium based on age	e, plan and option chose	en.)
Dental - \$2,000 Annual Limit Plans A & B only; Dental already include n Plan C)	<u> </u>			
rision (Available only for groups of 21+ w Il opt for the same benefit. Vision alrea ncluded in Plan C, \$500 Annual Limit)	ho 🗖dy			
Personal Accident Coverage				
Others:				<u> </u>
Subtotal Optional Benefits Premiu	m			
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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 (☐₱☐\$	——————————————————————————————————————	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 Over-the-counter Gcash Maya PHOTOS: Dependents						
2 x 2 phot of Depender		2 x 2 photo of Dependent 2	2 x 2 photo of Dependent 3			

CONTACT US -



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We also have Agency Offices in:

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