FLEXISHIELD APPLICATION GUIDE

Pacific Cross Insurance, Inc.
8 Rockwell Building, Hidalgo Drive,
Makati City, Metro Manila, Philippines

- This product is designed to respond when the Maximum Benefit Limit (MBL) of client's first layer HMO has been **exhausted** for the current policy year. The existing first layer HMO maximum benefit limit or annual benefit limit is **for each disability per year** that is **not less than PHP150,000** for ***15 days old to 75 years old***. Coverage based on *special arrangement* between the Policyholder and/or Insured and the first layer HMO shall not be regarded as an exhausted first layer HMO benefit. In *no instance* shall the Company provide coverage out of the *first layer HMO's utilization of inner limits or due to its limited coverage for specific medical conditions.*

- Declare the actual amount of your first layer HMO Plan's Maximum Benefit Limit (MBL). The Plan Names correspond to a **Deductible Range** and the absolute amount of the first layer HMO Plan's MBL shall be the same as that of the Deductible amount of FlexiShield. For example, if your first layer HMO Plan's MBL is **PHP165,000**, the applicable premium is that of **Plan FlexiShield 150** (Deductible Range from PHP150,000 to PHP199,000) and the Deductible amount shall be **PHP165,000**.

- **Pre-Existing Conditions declared** to the Company and assessed to be included by an Endorsement will be covered according to the terms specified therein. The Company *may permanently exclude* from cover a specific medical condition or Disability upon written notice to the Insured Person. **Pre-Existing Conditions** shall only be covered upon exhaustion of the First Layer HMO Plan's Maximum Benefit Limit or Annual Benefit Limit that are eligible based on the First Layer's Contract/Agreement.

- Failure to truthfully answer the questions in this application form, or *concealment*, or *misrepresentation* of any significant condition will result in the **voiding** of all the applicable member's benefits under the plan. Also, this application form may be returned to the client for failure to complete all details requested.

- If the first layer HMO plan is *terminated*, this second layer Policy will still be **in force until the end of the Period of Insurance** but only for *medical conditions* that the first layer HMO Contract could have covered prior its termination and as such, the Company will pay the eligible In-Patient medical expenses **after application of the Deductible**.

- This Policy may only be *renewed if the first layer HMO was also renewed*. For every renewal, the Company must be provided with the Insured Person's proof of existing and active first layer HMO.

- Pacific Cross must be immediately notified should there be **changes on the health status** of any of the persons to be insured after this application form is signed and before approval of application. Otherwise, Pacific Cross *reserves the right to render the policy void*.

FLEXISHIELD
APPLICATION FORM

Pacific Cross Insurance, Inc.
8 Rockwell Building, Hidalgo Drive, Makati City, Metro Manila, Philippines

PACIFIC CROSS

Application Reference No.: _____

Directions: Please answer this application form as truthfully as possible. All sections must be completed using a ballpen or signpen. Please use block letters. Application forms without the appropriate signatures and dates will be returned. This form is valid for 45 days from the date of your application.

2 x 2 photo of Principal Applicant

INSURANCE TYPE: ☐ **Individual** ☐ **Family (with 1 Dependent of minor age)**

PERSONAL INFORMATION: Principal Applicant

FIRST NAME:

MIDDLE NAME: LAST NAME:

MOTHER'S MAIDEN NAME:

BIRTHDATE: month day year PLACE OF BIRTH: NATIONALITY:

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

OCCUPATION: NATURE OF WORK (e.g., 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 ☐ Other (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	Date of Birth *(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 ☐ Other (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, 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 six (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 email 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:

DECLARATION OF EXISTING HMO

Name of existing HMO: _____ Type/Name of Plan: _____

Maximum Benefit Limit: _____ Effective Date *(mm/dd/yyyy)*: _____ Expiry Date *(mm/dd/yyyy)*: _____

Has the Policy been accepted on standard cover?
(This means that the existing Policy was accepted without extra premium loading, exclusions, and limitations.) ☐ YES ☐ NO.

If NO, please provide details (e.g., terms offered and reason). _____

For Internal Use Only

Date Received: _____

SELLER'S DETAILS

☐ DIRECT (AE's ID No.:_____) ☐ INTERMEDIARY If Broker, name of Company: _____
If Agent, name of Agent: _____
Broker/Agent Code: _____

PRODUCT and PLAN DETAILS

Effectivity Date (mm/dd/yyyy): _____

☐ New Applicant ☐ Additional Applicant ☐ Reapplication

REMARKS:

DEPENDENT/S TO BE INSURED

Please state the details of Dependent of minor age (i.e., Child for married applicant and Sibling for single applicant). If there is more than one (1) dependent, please use the fillable Word version of this application form. *Dependent* Spouse or Parent of legal age may use this form separately as a **Principal Applicant**.

DEPENDENT Relationship to Principal Applicant: _____

2 x 2 photo of Dependent

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: ☐ Male ☐ Female NATIONALITY: _____ WEIGHT: _____ lbs. HEIGHT: _____ feet _____ inches

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

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

NAME OF EMPLOYER:
(if applicable) _____ If self-employed, type of industry: _____

	Name	Date of Birth *(mm/dd/yyyy)*	Place of Birth	Relationship to Dependent	Contact Number
BENEFICIARY:					

ADDRESS: _____ SEX: ☐ Male ☐ Female NATIONALITY: _____

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

MEDICAL QUESTIONNAIRE

DIRECTIONS: Please tick YES or NO to every question for each person to be insured.	**First Name of Applicant** _____		**First Name of Dependent** _____	
	YES	**NO**	**YES**	**NO**
1. Have you ever been diagnosed with, or are currently under investigation for cancer, leukemia, heart disease, or undergoing dialysis? *Heart disease refers to heart attack, heart failure, coronary artery disease, ischemic heart disease, heart valvular disease, and/or cardiac arrhythmia*	❑	❑	❑	❑
2. a. Since the last two (2) years, are you taking or do you need to take medications, treatment or injections (whether prescribed or not) on a regular basis? *This excludes vitamins, food and health supplements, and antioxidants.*	❑	❑	❑	❑
b. In the last two (2) years, have you taken or been required to take medications, treatment or injections for more than ten (10) consecutive days for any reason? *This excludes vitamins, food and health supplements, and antioxidants.*	❑	❑	❑	❑
3. a. In the last two (2) years, have you been admitted to a hospital for more than five (5) consecutive days?	❑	❑	❑	❑
b. In the last two (2) years, have you been admitted on two (2) or more occasions within a one (1) year period for any number of days for the same or related/connected cause?	❑	❑	❑	❑
4. Have you in the last three (3) months had any medical consultation, undergone any surgery or out-patient procedures of any kind, taken any medical tests, taken any prescribed medical treatment or been advised to have such consultation, tests or treatment for any reason or are considering to have any medical consultation or tests for any reason? *This excludes routine health check-up or Annual Physical Examination.*	❑	❑	❑	❑

If you tick YES to any of the questions, please provide DETAILS OF YES RESPONSES and attach the corresponding MEDICAL REPORTS indicated below. Please ensure that you tell us about all your medical conditions and symptoms, whether past and/or present, known and/or suspected, whether or not professional advice was sought. If you were previously or already are a Pacific Cross customer and you are applying to increase cover or you are applying as a new business under any Pacific Cross product, please include details of any condition for which you have filed claims since joining Pacific Cross.

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:			**Remarks:**		
❑ Medical test results ❑ Utilization/claims report ❑ Medical certificate ❑ Others: _____					
Name of Dependent:					
Attachments:			**Remarks:**		
❑ Medical test results ❑ Utilization/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. Pre-Existing Conditions shall only be covered upon exhaustion of the First Layer HMO Plan's Maximum Benefit Limit or Annual Benefit Limit that are eligible based on the First Layer's Contract/Agreement. Coverage based on special arrangement between the Policyholder and/or Insured and the First Layer HMO shall not be regarded as an exhausted First Layer Plan Benefit. In no instance shall Flexishield coverage be provided out of the First Layer HMO Plan's utilization of inner limits (per item limit) or due to its limited coverage for specific medical conditions. 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 benefits arising from such conditions and all its sequelae and/or conditions/complications related thereto 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:
    a. 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 membership card/s 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 name of Principal Applicant:	Signature over printed name of Spouse:
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):
Date: *Month* *Day* *Year*	Place of signing:

NOTED BY:

I ensure that I, as the agent/AE/broker, have guided the client 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 client 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: *Month* *Day* *Year*	If Broker/Agent, please indicate agent's code:

PAYMENT OPTIONS

TERMS OF PAYMENT: ☐ Annual (☐ ₱ _____)

MODE OF PAYMENT:

☐ Cash

☐ Check (Please make check payable to Pacific Cross Insurance, Inc.)

☐ Bills Payment ☐ BDO ☐ Metrobank

☐ Credit Card-Present Transaction: available for ***Straight Payment*** or ***Deferred Payment***
For ***Deferred Payment***, accepted credit cards are **BDO, BPI, Metrobank, EastWest Bank and Bank of Commerce**

☐ Credit Card Key-In Transaction: available for ***Straight Payment*** or ***Deferred Payment***
For ***Deferred Payment***, accepted credit cards are **BDO, BPI, EastWest Bank and Bank of Commerce**. (*Please fill out a Flexishield Credit Card Authorization Form for key-in transaction. You may request a copy of the form from our Medical Sales Representatives or download a copy from our website.*)

☐ Web Payment (Pacific Cross's online payment gateway accepts credit cards, debit cards, and GCash payments through www.pacificcross.com.ph.)

CONTACT US

PACIFIC CROSS

HEAD OFFICE

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PROVINCIAL OFFICES

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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.
Application forms are also available on our website for download.**