MEMBER APPLICATION FORM FOR GROUP MEDICAL PLAN

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

Application Reference No.: _____

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.

Client/Group/Company Name:

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:		**NATURE OF WORK** (Administration, Sales, etc.)**:**	
NAME OF EMPLOYER:		**If self-employed, please state the nature of business:**	
SOURCES OF FUNDS OR PROPERTY:	☐ Salary ☐ Business ☐ Others (Please specify.): _____		
GOV'T ISSUED CARD:	☐ Passport ☐ TIN ☐ SSS ☐ GSIS ☐ Driver's License ☐ Others (Please specify.): _____		
CARD 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: _____)		

BENEFICIARY:

NAME:			
BIRTHDATE (mm/dd/yyyy)**:**		**PLACE OF BIRTH:**	
RELATIONSHIP TO PRINCIPAL APPLICANT:		**CONTACT NUMBER:**	
SEX: ☐ Male ☐ Female		**NATIONALITY:**	
ADDRESS:			
GOV'T ISSUED CARD:	☐ Passport ☐ TIN ☐ SSS ☐ GSIS ☐ Driver's License ☐ Others (Please specify.): _____		
CARD NO.:			

CONTACT INFORMATION

PERMANENT ADDRESS (Home Country) (Number, Street, Block, Subdivision, City, Zip Code, Province, Country)
PRESENT ADDRESS (Country of Residence): *Must be the Member's place of residence or place of employment for not less than six (6) months within the Period of Agreement. It is deemed to be the Philippines unless otherwise declared and covered by an Endorsement to the Agreement.*
RESIDENCE (Number, Street, Block, Subdivision, City, Zip Code, Province, Country)
BUSINESS (Number, Street, Block, Subdivision, City, Zip Code, Province, Country)

E-MAIL ADDRESS*:	

**This e-mail address will be used for sending your agreement forms which may include sensitive medical information. Your membership card and all agreement forms 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 (mm/dd/yyyy):			
☐ 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	☐ Re-Application	
REMARKS:			

DEPENDENTS TO BE ENROLLED

For Single Applicant - Please state names of parents first, followed by siblings (from eldest to youngest) and followed by allowable extended relatives.
For Married Applicant - Please state name of spouse first, followed by children (from eldest to youngest) and followed by allowable extended relatives. **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:**	

BIRTHDATE (mm/dd/yyyy)**:**		**BIRTHPLACE:**	
PRESENT ADDRESS: *(if different from Principal Applicant)*			
E-MAIL ADDRESS:		**RESIDENCE TEL. NO.:**	**MOBILE NO.:**
SEX: ☐ Male ☐ Female	**NATIONALITY:**	**WEIGHT** (lbs.)**:**	**HEIGHT** (ft. & in.)**:**
GOV'T ISSUED CARD:	☐ Passport ☐ TIN ☐ SSS ☐ GSIS ☐ Driver's License ☐ Others (Please specify.): _____		
CARD NO.:			
OCCUPATION:		**NATURE OF WORK** (Administration, Sales, etc.)**:**	
NAME OF EMPLOYER: (if applicable)		**If self-employed, please state the type of industry:**	

BENEFICIARY:

NAME:			
BIRTHDATE (mm/dd/yyyy)**:**		**PLACE OF BIRTH:**	
RELATIONSHIP TO DEPENDENT 1:		**CONTACT NUMBER:**	
SEX: ☐ Male ☐ Female	**NATIONALITY:**		
ADDRESS:			
GOV'T ISSUED CARD:	☐ Passport ☐ TIN ☐ SSS ☐ GSIS ☐ Driver's License ☐ Others (Please specify.): _____		
CARD NO.:			

DEPENDENT 2			
Relationship to Principal Applicant:			
FIRST NAME:			
MIDDLE NAME:		**LAST NAME:**	
BIRTHDATE (mm/dd/yyyy)**:**		**BIRTHPLACE:**	
PRESENT ADDRESS: *(if different from Principal Applicant)*			
E-MAIL ADDRESS:		**RESIDENCE TEL. NO.:**	**MOBILE NO.:**
SEX: ☐ Male ☐ Female	**NATIONALITY:**	**WEIGHT** (lbs.)**:**	**HEIGHT** (ft. & in.)**:**
GOV'T ISSUED CARD:	☐ Passport ☐ TIN ☐ SSS ☐ GSIS ☐ Driver's License ☐ Others (Please specify.): _____		
CARD NO.:			
OCCUPATION:		**NATURE OF WORK** (Administration, Sales, etc.)**:**	
NAME OF EMPLOYER: (if applicable)		**If self-employed, please state the type of industry:**	

BENEFICIARY:

NAME:			
BIRTHDATE (mm/dd/yyyy)**:**		**PLACE OF BIRTH:**	
RELATIONSHIP TO DEPENDENT 2:		**CONTACT NUMBER:**	
SEX: ☐ Male ☐ Female	**NATIONALITY:**		
ADDRESS:			
GOV'T ISSUED CARD:	☐ Passport ☐ TIN ☐ SSS ☐ GSIS ☐ Driver's License ☐ Others (Please specify.): _____		
CARD NO.:			

DEPENDENT 3

Relationship to Principal Applicant:					
FIRST NAME:					
MIDDLE NAME:		**LAST NAME:**			
BIRTHDATE (mm/dd/yyyy)**:**		**BIRTHPLACE:**			
PRESENT ADDRESS: *(if different from Principal Applicant)*					
E-MAIL ADDRESS:		**RESIDENCE TEL. NO.:**		**MOBILE NO.:**	
SEX: ☐ Male ☐ Female	**NATIONALITY:**		**WEIGHT** (lbs.)**:**		**HEIGHT** (ft. & in.)**:**
GOV'T ISSUED CARD:	☐ Passport ☐ TIN ☐ SSS ☐ GSIS ☐ Driver's License ☐ Others (Please specify.): _____				
CARD NO.:					
OCCUPATION:		**NATURE OF WORK** (Administration, Sales, etc.)**:**			
NAME OF EMPLOYER: (if applicable)		**If self-employed, please state the type of industry:**			

BENEFICIARY:

NAME:			
BIRTHDATE (mm/dd/yyyy)**:**		**PLACE OF BIRTH:**	
RELATIONSHIP TO DEPENDENT 3:		**CONTACT NUMBER:**	
SEX: ☐ Male ☐ Female	**NATIONALITY:**		
ADDRESS:			
GOV'T ISSUED CARD:	☐ Passport ☐ TIN ☐ SSS ☐ GSIS ☐ Driver's License ☐ Others (Please specify.): _____		
CARD NO.:			

MEDICAL QUESTIONNAIRE

DIRECTIONS: Please tick YES or NO to every question for each person to be enrolled.	**First Name of Applicant** _____		**First Name of 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? (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?	☐	☐	☐	☐	☐	☐	☐	☐
a. If yes, for how long?	_____ years		_____ years		_____ years		_____ years	
b. If still a smoker, how many cigarette sticks per day?	_____ cig. sticks		_____ cig. sticks		_____ cig. sticks		_____ cig. sticks	
4. Do you engage in any form of sports? Please specify.	_____		_____		_____		_____	
If you tick YES to any of the questions, please provide DETAILS OF YES RESPONSES and attach the corresponding MEDICAL REPORTS indicated on page 7. 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 Client 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.								
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?	☐	☐	☐	☐	☐	☐	☐	☐
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 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?	☐	☐	☐	☐	☐	☐	☐	☐
k. hormone, endocrine or glandular disorder or condition like: k1. diabetes k2. thyroid (ex: goiter) /parathyroid disorder k3. obesity k4. endocrine tumors k5. others (Please specify. _____)?	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
l. (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?	☐	☐	☐	☐	☐	☐	☐	☐

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: ☐ Medical test results ☐ Utilization/claims report ☐ Medical certificate ☐ Others:			**Remarks:**		
Name of Dependent 1:					
Attachments: ☐ Medical test results ☐ Utilization/claims report ☐ Medical certificate ☐ Others:			**Remarks:**		
Name of Dependent 2:					
Attachments: ☐ Medical test results ☐ Utilization/claims report ☐ Medical certificate ☐ Others:			**Remarks:**		
Name of Dependent 3:					
Attachments: ☐ Medical test results ☐ Utilization/claims report ☐ Medical certificate ☐ 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 Member'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 membership fee loading may be applied subject to the results of the medical evaluation. I understand that Pacific Cross Health Care, 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 Agreement.

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

- Unless declared to the company and have been included for coverage by an Endorsement, Pre-Existing Conditions are conditions which are not covered on the first year of the Agreement. On the second year and every year thereafter, utilization related to Pre-Existing Conditions will be covered only upon payment of additional membership fee 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 Agreement.

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 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 Commission Regulated Entities are required to satisfactorily establish the identities of all its customers. Hence, Pacific Cross Health Care, 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 Agreement, the Client 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 Client, the Company may apply the following:
    a. Measures to restrict the services available or prohibit any further transactions on the Client 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 Client to receive the unused portions of membership fee 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 Agreement, Membership Card 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 agreement 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.

CLIENTS' 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 agreement; (6) Right to receive the agreement; (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:	
Name of Spouse:	
Signature of Spouse:	
Name of Legal Age Dependent:	
Signature of Legal Age Dependent:	
If the Dependent is a minor, please state the name of Applicant – payor (e.g., parent or guardian)**:**	
Signature of Applicant – payor:	
Date (mm/dd/yyyy)**:**	
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 Member 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.

Name of Account Executive/Broker/Agent:	
Signature of Account Executive/Broker/Agent:	

Date (mm/dd/yyyy)**:**		**If Broker/Agent, please indicate broker's/agent's code:**	

PHOTOS: Principal Applicant and Dependents

2x2 photo of Principal Applicant

2x2 photo of Dependent 1

2x2 photo of Dependent 2

2x2 photo of Dependent 3

CONTACT US

HEAD OFFICE
2nd Floor (Client & Partner Center), 8th Floor (Sales Center)
and 18th Floor (Operations & Executive Center),
8 Rockwell Building, Hidalgo Drive, Makati City, Metro Manila, Philippines
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PROVINCIAL BRANCHES

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CLARK
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DAVAO
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E-mail: davao@pacificcross.com.ph

Pacific Cross remains **#HereForYou** in several provincial locations.
For the complete details of our Agency Offices, please visit www.pacificcross.com.ph/our-offices/

You may request additional copies of this application form from our Medical Sales Representatives.
Application forms are also available on our website for download.