POLICYHOLDER APPLICATION FORM FOR GROUP MEDICAL PLAN

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.

POLICYHOLDER INFORMATION

COMPANY NAME (Legal Name):					
OFFICE ADDRESS:					
TEL. NO.:		**FAX NO.:**		**COMPANY TIN:**	

CONTACT PERSON'S DETAILS

FIRST NAME:			
MIDDLE NAME:		**LAST NAME:**	
POSITION:		**E-MAIL ADDRESS:**	
TEL. NO.:		**FAX NO.:**	
GOV'T ISSUED CARD:	☐ Passport ☐ TIN ☐ SSS ☐ GSIS ☐ Driver's License ☐ Others (Pls. specify): _____		
CARD NO.:			

AUTHORIZED REPRESENTATIVE 1 DETAILS (If different from Contact Person)

FIRST NAME:			
MIDDLE NAME:		**LAST NAME:**	
POSITION:		**E-MAIL ADDRESS:**	
TEL. NO.:		**FAX NO.:**	
GOV'T ISSUED CARD:	☐ Passport ☐ TIN ☐ SSS ☐ GSIS ☐ Driver's License ☐ Others (Pls. specify): _____		
CARD NO.:			

AUTHORIZED REPRESENTATIVE 2 DETAILS (If any)

FIRST NAME:			
MIDDLE NAME:		**LAST NAME:**	
POSITION:		**E-MAIL ADDRESS:**	
TEL. NO.:		**FAX NO.:**	
GOV'T ISSUED CARD:	☐ Passport ☐ TIN ☐ SSS ☐ GSIS ☐ Driver's License ☐ Others (Pls. specify): _____		
CARD NO.:			

POLICYHOLDER CLASSIFICATION:	☐ Corporation ☐ Non-Profit ☐ Partnership ☐ Sole Proprietor ☐ Others (Pls. specify): _____
NATURE OF BUSINESS:	
DATE WHEN BUSINESS WAS ESTABLISHED:	

BENEFICIARY AND/OR BENEFICIAL OWNER (*whenever applicable*) INFORMATION

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

For Internal Use Only

SELLER'S DETAILS:

Date Received:			
☐ 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:				
☐ New Applicant	☐ Additional Applicant	☐ Re-Application	☐ Take-Over Account	☐ Transferee
State insurance company/HMO (If a Take-Over Account):				
REMARKS:				

MEDICAL INSURANCE

ELIGIBLE PERSONS:	☐ Insured Only	☐ Insured and Eligible Dependents	
BASIS OF INSURED COVERAGE:	☐ By Salary	☐ By Category	☐ Others. (Please specify. _____)
PLAN:	☐ BC Flexi Baby Group	☐ Others. (Please specify. _____)	
PREMIUM PAYMENT:	☐ Non-Contributory (Policyholder)	☐ Contributory (Policyholder and Insured)	☐ Voluntary (Insured)
MODE OF PAYMENT:	☐ Annual	☐ Semi-Annual	☐ Quarterly (minimum of PHP300,000 per quarter is required)

PREVIOUS MEDICAL INSURER OR HMO:	

INSURED INFORMATION

NUMBER OF INSUREDS:

Actively at Work and Regular Employees/Insureds:	
Contractual and Irregular Employees/Insureds:	
Others:	

I certify that the above information is true and correct to the best of my knowledge. I understand that for the contributory group, 100% of eligible Insureds belonging to the group will be covered. For the contributory and voluntary group, not less than 75% of eligible Insureds will be covered. The Benefits provided under this plan are subject to the provisions of the Policy.

I further certify that the signatures affixed in each of the application forms under this Group Medical Plan are authentic signatures of Insureds (including their dependents, where applicable). In situations where the official individual application form is not required, I further certify that the information indicated in the group enrollment form are true and correct.

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 Insurance, Inc. reserves the right not to accept and process any application for medical plan 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.

DATA PRIVACY CONSENT: I understand that Pacific Cross collects and uses my personal information in order to service and administer my Insurance Policy, to 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 data.

Name of Authorized Company Representative 1:	

Signature of Authorized Company Representative 1:	

Name of Authorized Company Representative 2 (if any):	

Signature of Authorized Company Representative 2:	

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

Place of signing:	

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.

Name of Account Executive/Broker/Agent:	

Signature of Account Executive/Broker/Agent:	

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

CONTACT US

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We also have Agency Offices in:
Luzon: Batangas | Cavite | Laguna | Manila | Naga | Palawan | Pampanga | Taguig
VisMin: Bacolod | Bohol | Butuan | Cagayan de Oro | 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.