APPLICATION FOR REINSTATEMENT OF INSURANCE POLICY

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

Policy No.:		**Date of Lapse** (mm/dd/yyyy)**:**	
First Name of Insured:			
Middle Name of Insured:			
Last Name of Insured:			
Name of Policyholder/Principal Insured:			

PLAN TYPE:

☐ Select Medical Plan ☐ Premier Medical Plan ☐ Blue Royale Medical Plan
☐ Others (Please specify.): _____

Payment Amount:		**Payment Date** (mm/dd/yyyy)**:**		**Official Receipt No.:**	

I hereby apply for reinstatement of my Policy by executing this declaration and payment of all amounts in arrears. I understand that the reinstatement shall take effect only upon payment of the required premium, including any loading, and upon prior approval of such reinstatement by Pacific Cross at its Head Office. Payment of the premium should be settled within 10 days after reinstatement approval date.

I hereby represent and declare to the best of my knowledge, since the Company's approval of my application form and acceptance of my first premium payment under this medical insurance coverage, also referred to as the initial enrollment date, that:

a. I am in good health and good physical condition;
b. I have not consulted a physician or practitioner for medical attention or surgical advice and treatment and have not been confined in a hospital, sanatorium or infirmary at any time for any cause;
c. I have not applied for any medical plan which has been declined, postponed or modified in coverage, rider or premium.

(If there is any exception to the above statement, kindly state full details below. You may use the back portion of this form, if necessary.)

EXCEPTIONS:	

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 agree that if no exception is listed in the blank space provided for such exception, it shall have the same force and effect as if the word "NONE" was written therein.

I understand that failure to declare truthfully, or concealment, or misrepresentation of any significant condition in this declaration will result in the voiding of all the applicable insured's benefits under the plan.

I also understand that I cannot recover any claim amount for injury or illness that happened during the period that my Policy was lapsed. I further understand that benefits only become eligible for injuries that may occur after the reinstatement approval date, and for illnesses occurring wholly after 10 days from such reinstatement approval date.

I agree that my Policy shall not be considered reinstated until all other requirements for the reinstatement are fully satisfied and until this application is approved by Pacific Cross at its Head Office. I further agree that prior to the approval of my application, any payment made or to be made shall only be considered as a deposit, which shall be refunded to me upon notice of cancellation, non-acceptance or disapproval.

I further agree that the approval of the reinstatement is conditioned on the truthfulness of the above statements.

DATA PRIVACY CONSENT: I understand that Pacific Cross collects and uses my personal data to service and administer my insurance policy, to provide appropriate and timely medical services, and for the purposes provided in the Pacific Cross Privacy Statement attached to this application form (also available at www.pacificcross.com.ph). By signing this application form, I acknowledge that I have read and agree to the terms of the Privacy Statement, and understand that my data may be collected, shared, disclosed, transferred, used or otherwise processed by Pacific Cross in accordance with the Data Privacy Act of 2012, its implementing rules and regulations, and the Privacy Statement. 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.

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

Name of Insured:	

Signature of Insured (If Insured is Minor, signature of Parent/Guardian)**:**	

Name of Witness:	

Signature of Witness:	

Name of Policyholder:	

Signature of Client: (If Insured is other than Policyholder)**:**	

CONTACT US

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

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