# PERSONAL ACCIDENT INSURANCE
## APPLICATION FORM

**Pacific Cross Insurance, 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. 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.

### I. PERSONAL INFORMATION OF THE 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.:** | | | |

## II. CONTACT INFORMATION:

| **PERMANENT ADDRESS (Home Country)**<br>(Number, Street, Block, Subdivision, City, Zip Code, Province, Country) | |
|---|---|
| | |
| **PRESENT ADDRESS (Country of Residence):** *Must be the Insured's place of residence or place of employment for not less than 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.* | |
| **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 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:** | | | | | |

## III. PERSONAL ACCIDENT COVERAGE:

| **Plan:** | |
|---|---|

## IV. DEPENDENTS TO BE INSURED (If applicable):

**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.**

| **DEPENDENT 1 (i.e., Spouse or Parent)** | | | | | |
|---|---|---|---|---|---|
| **Relationship to Principal Applicant:** | | | | | |
| **FIRST NAME:** | | | | | |
| **MIDDLE NAME:** | | **LAST NAME:** | | | |
| **BIRTHDATE** (mm/dd/yyyy)**:** | | **BIRTHPLACE:** | | | |
| **PRESENT ADDRESS:**<br>*(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**<br>(Administration, Sales, etc.)**:** | | | |

| | | | |
|---|---|---|---|
| **NAME OF EMPLOYER:** (if applicable) | | **If self-employed, please state the nature of business:** | |

**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 nature of business:** | | | | | |

**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 nature of business:** | | | | | |

**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.:** | | | |

## V. QUESTIONNAIRE:

| **DIRECTIONS: Please tick YES or NO to every question for each person to be insured.** | **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. Do you currently have a Life, Personal Accident or Medical Insurance with Pacific Cross or any other insurance company? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Have you ever made a claim under an accident policy? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Have you ever had any Life, Personal Accident or Medical Insurance declined, cancelled or refused for renewal? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Do you intend to travel by air? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 5. Do you engage in hazardous sports, aeronautics or contemplate any special journey or hazardous undertaking? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| **For Sum Insured PHP 2,500,000 and up only:** 6. During the past five (5) years, have you ever been disabled or suffered from any disease, hospitalized or received medical treatment? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| **If you tick YES to any of the questions, please provide DETAILS OF YES RESPONSES.** | | | | | | | | | |

## DETAILS OF YES RESPONSES

| **Name of Principal Applicant:** | | | |
|---|---|---|---|
| **If Yes to Question No. 1, please give details:** | | | |
| **Company** | **Type of Insurance** | **Amount of Insurance** | **Date** |
| | | | |
| **If Yes to Question No. 2, please give details (Name of insurer, date of claim, claim amount, and reason for claim):** | | | |
| **If Yes to Question No. 3, please give details (Name of insurer, date of application, and reason for cancellation or refusal):** | | | |
| **If Yes to Question No. 4, please state how frequently in the course of a year and the kind of services used:** | | | |
| **If Yes to Question No. 5, please give details:** | | | |
| **If Yes to Question No. 6, please give details including date of disability/hospitalization and current status:** | | | |

| **Name of Dependent 1:** | | | |
|---|---|---|---|
| **If Yes to Question No. 1, please give details:** | | | |
| **Company** | **Type of Insurance** | **Amount of Insurance** | **Date** |
| | | | |
| **If Yes to Question No. 2, please give details (Name of insurer, date of claim, claim amount, and reason for claim):** | | | |
| **If Yes to Question No. 3, please give details (Name of insurer, date of application, and reason for cancellation or refusal):** | | | |
| **If Yes to Question No. 4, please state how frequently in the course of a year and the kind of services used:** | | | |
| **If Yes to Question No. 5, please give details:** | | | |
| **If Yes to Question No. 6, please give details including date of disability/hospitalization and current status:** | | | |

| Name of Dependent 2: | | | |
|---|---|---|---|
| **If Yes to Question No. 1, please give details:** | | | |
| **Company** | **Type of Insurance** | **Amount of Insurance** | **Date** |
| | | | |
| **If Yes to Question No. 2, please give details (Name of insurer, date of claim, claim amount, and reason for claim):** | | | |
| **If Yes to Question No. 3, please give details (Name of insurer, date of application, and reason for cancellation or refusal):** | | | |
| **If Yes to Question No. 4, please state how frequently in the course of a year and the kind of services used:** | | | |
| **If Yes to Question No. 5, please give details:** | | | |
| **If Yes to Question No. 6, please give details including date of disability/hospitalization and current status:** | | | |

| Name of Dependent 3: | | | |
|---|---|---|---|
| **If Yes to Question No. 1, please give details:** | | | |
| **Company** | **Type of Insurance** | **Amount of Insurance** | **Date** |
| | | | |
| **If Yes to Question No. 2, please give details (Name of insurer, date of claim, claim amount, and reason for claim):** | | | |
| **If Yes to Question No. 3, please give details (Name of insurer, date of application, and reason for cancellation or refusal):** | | | |
| **If Yes to Question No. 4, please state how frequently in the course of a year and the kind of services used:** | | | |
| **If Yes to Question No. 5, please give details:** | | | |
| **If Yes to Question No. 6, please give details including date of disability/hospitalization and current status:** | | | |

I warrant the truth of all the statements in this application form and agree to give notice to the Company of any variation in profession or occupation, health, habits or pursuits, or the effecting insurances against Accident, disease or sickness.

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 is subject to evaluation. I understand that a premium loading may be applied subject to the results of the evaluation. I understand that Pacific Cross Insurance, Inc. reserves the right to decline application for coverage based on the results of the evaluation.

I certify that I am informed of the benefits, exclusions and all other provisions of 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 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.

| | |
|---|---|
| **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 insured is a minor, name of Applicant – payor** (e.g., parent or guardian)**:** | |
| **Signature of Applicant – payor:** | |
| **Date** (mm/dd/yyyy)**:** | |
| **Place of signing:** | |

The Liability of the Company does not commence until the Proposal has been accepted by the Company and the premium paid. The Policy is issued only upon payment of the premium, premium tax, and documentary stamps.

**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:** | |
|---|---|---|---|

## 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 ☐ Take-Over Account ☐ Transferee | |
| Stand-alone Personal Accident: | |
| Personal Accident Rider: | |
| **State insurance company/HMO (If a Take-Over Account):** | |
| **REMARKS:** | |

## PAYMENT OPTIONS

| | | |
|---|---|---|
| **TERMS OF PAYMENT:** | ☐ Annual<br>( ☐ ₱ ) | ☐ Semi-Annual (8% surcharge and DST charge will apply)<br>( ☐ ₱ ) |
| **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<br>• GCash<br>• Dragon Pay<br>• Maya | • Mlhuillier<br>• BPI/PNB Online Bills payment<br>• 7/11 |

## PHOTOS: Principal Applicant and Dependents

| **2 x 2 photo of Principal Applicant** |
|---|
| |

| **2 x 2 photo of Dependent 1** |
|---|
| |

| **2 x 2 photo of Dependent 2** |
|---|
| |

| **2 x 2 photo of Dependent 3** |
|---|
| |