

# CREDIT CARD AUTHORIZATION FORM HEALTHCARE COVERAGE

Pacific Cross Health Care, Inc.



## Client's Information

|                 |                |                |  |
|-----------------|----------------|----------------|--|
| Name of Client: |                |                |  |
| Date of Birth:  | Month Day Year | Telephone No.: |  |
| Debit Note No.: |                | Agreement No.: |  |

## Payment Terms

|                          |                                                                                                                                                                                                                         |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <b>Straight Payment</b>                                                                                                                                                                                                 |
| <b>CARD TYPE:</b>        | <input type="checkbox"/> MASTERCARD <input type="checkbox"/> VISA <input type="checkbox"/> AMEXCO <input type="checkbox"/> JCB                                                                                          |
| <input type="checkbox"/> | <b>Deferred Payment (Available for locally issued credit cards and Peso premiums with a minimum payment of PHP3,000.00. This will be subject to additional fees as charged by the issuing bank of the credit card.)</b> |
| <b>BANK:</b>             | <input type="checkbox"/> BDO <input type="checkbox"/> BPI                                                                                                                                                               |
| <b>TERMS:</b>            | <b>Regular Installment:</b> <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 9 months <input type="checkbox"/> 12 months                                                    |

## Cardholder's Information

|                                                                  |  |               |  |
|------------------------------------------------------------------|--|---------------|--|
| Name of Cardholder:                                              |  |               |  |
| Relationship to Client (If Cardholder is other than the Client): |  |               |  |
| Credit Card No.:                                                 |  |               |  |
| Card Expiry Date (day/month/year):                               |  | Issuing Bank: |  |
| Contact No.:                                                     |  |               |  |

## Authorization

I certify that all information is complete and accurate. I hereby authorize Pacific Cross Health Care, Inc. to charge the amount of ₱ \_\_\_\_\_ to my credit card account. I certify that I am the authorized signatory of the credit card listed above.

**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 (available at [www.pacificcross.com.ph](http://www.pacificcross.com.ph)). By signing this 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.

Cardholder's Name & Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- NOTES:**
- A photocopy of at least one (1) valid ID bearing your photo and signature, and a photocopy of your credit card bearing the card details (except for CVV/CVC) are required. The copy of CVV/CVC should not be attached to this form for security purposes.
  - In case of non-submission of the above requirements, please expect a confirmation call from a Pacific Cross representative to verify the information provided.
  - Please send the filled out Credit Card Authorization Form to 2nd Floor, 8 Rockwell Building, Hidalgo Drive, Makati City, Metro Manila, Philippines, or  
➤ Fax to +63 2 8230-8574 (for Renewal) ➤ E-mail to [rccp@pacificcross.com.ph](mailto:rccp@pacificcross.com.ph) (for Renewal); your assigned Account Executive (for New Business)

**\*To be filled out by Finance/Sales Representative**

|                                                   |                                |              |              |
|---------------------------------------------------|--------------------------------|--------------|--------------|
| <b>Confirmed by:</b><br>(Name & Signature)        | <b>Date:</b><br>Month Day Year |              |              |
| <b>Processed/Swiped by:</b><br>(Name & Signature) | <b>Approval Code:</b>          | <b>Bank:</b> | <b>Date:</b> |