PACIFIC CROSS

NOTIFICATION OF CLAIM - CRITICAL COVER EXTRA

ALL SECTIONS MUST BE COMPLETELY FILLED OUT.

A. PARTICULARS OF CLAIMANT

Patient's Name: _____
Last Name First Name Middle Initial

Birthday: _____ The Patient is a ❑ Principal Insured ❑ Dependent
DAY / MONTH / YEAR

Policy ID Number (of Principal Insured): _____

Contact Details:

Home Address: _____ Tel. No.: _____

Office Address: _____ Tel. No.: _____

Mobile Phone No.: _____ Fax No.: _____

E-mail Address: _____

If you are insured with another company for related or similar benefits to Pacific Cross Critical Cover Extra, please provide details below.

Name of Insurer	Type of Benefit	Amount of Benefit	Has a claim been submitted?
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No

B. AUTHORITY, RELEASE and DECLARATION STATEMENTS

Authority: I hereby authorize the Company (Pacific Cross Insurance, Inc. and/or Pacific Cross Health Care, Inc.) and all persons duly authorized and acting in 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 claim, and such other matters related thereto. A photocopy of this is considered an original for all intents and purposes.

Release and Subrogation: Payment received by me shall constitute as full, final and complete settlement of this claim. I further agree that the Company is subrogated to my rights of recovery on all claims and rights of action to the extent of the payments made and/or on account of the losses incurred or which may be incurred by the Company against any person, corporation or entity in connection with this claim and I further agree to authorize the Company to commence all legal actions and proceedings necessary to enforce my claim or recovery thereof with any undertaking to extend my cooperation or assistance whenever necessary.

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). 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.

Declaration: I declare that all particulars stated on all pages of this form are complete and true, whether written by me or by anyone else on my behalf, shall be binding on me, and that the amounts being claimed herein are lawfully due to me under the terms and conditions of the Policy.

_____ _____
Signature over Printed Name of Patient or of Principal Insured, if Patient is a Minor — Date

Note: For Critical Illness claims resulting in death, the signatory of this form should be the Claimant's Beneficiary or legal representative.

C. PAYMENT OPTIONS (For payment processing, please indicate your preferred mode of payment for approved claims.)

❑ **DIRECT CREDIT TO MY NOMINATED BANK ACCOUNT**

❑ BDO ❑ Metrobank ❑ BPI ❑ Eastwest ❑ UnionBank

❑ Other Banks

Bank and Branch of Account: _____

Account Name: _____

Account No.: _____

Account Type: ❑ S/A ❑ C/A

SWIFT Code: _____

Account Holder's Address: _____

For Blue Royale Policies only, please indicate preferred currency of transfer:

❑ Peso ❑ Dollar (for those with USD Bank Accounts only)

Bank Account Name: _____ Bank Account No.: _____

Notes: 1. Whenever applicable, cost of interbranch crediting will be deducted from the approved claim amount.
2. In some cases, nominated banks may deduct fees from the approved claim amount.
3. A processing fee of PhP 100.00 will be deducted from your claim resulting from the incorrect information provided by claimant.

❑ **GCASH**

Note: 1. Please fill out the GCash Registration Form. Copies are available for request from the reception area of our Head Office. Soft copies may also be downloaded from the website.

D. CLAIMANT'S STATEMENT

1. Please provide details of any medical practitioners you have consulted and received medical treatment from in connection with your condition.

Date of Consultation	Doctor's Name	Hospital and Tel. No.	Regular Physician (Yes/No)

2. Please state the name, address and, contact number of your regular physician (if not stated in no. 1 above).

Name of Physician: _____

Address: _____

Contact No.: _____

For how long has he been your regular physician? _____

3. Please provide details of hospitals or institutions you were confined in connection with your condition.

Admission Date	Discharge Date	Name of Hospital/Institution

4. Have you ever had any illness in the last five (5) years? ❑ **Yes** ❑ **No** If *Yes*, please provide details below.

Details/Medical Condition	Nature/Date of Treatment	Current Status	Doctor's Name	Doctor's Current Info. (Address, Phone, Fax)

5. Do you smoke or have you smoked in the past? ❑ **Yes** ❑ **No**
   If *Yes*, please provide the number of cigarettes/cigars smoked per day: _____

6. Have you been drinking alcohol? ❑ **Yes** ❑ **No**
   If *Yes*, a.) Please state type (spirits, wine, beer, etc.): _____
   b.) Please state quantity of intake (centiliter, units, glasses, bottles, etc.) per week: _____

7. Have you ever used any habit-forming drugs or narcotics? ❑ **Yes** ❑ **No**
   If *Yes*, please provide details: _____
   _____

E. ATTENDING PHYSICIAN'S STATEMENT

1. Critical Illness Condition (Place a check mark on the Critical Illness patient is diagnosed of.)

❑ Cancer (Type: _____)
❑ Multiple Sclerosis
❑ Myocardial Infarction
❑ Benign Brain Tumor
❑ Cerebrovascular Accident (Stroke)
❑ Coronary Artery By-pass Surgery
❑ Kidney/Renal Failure
❑ Major Organ Transplant

2. Exact date when first symptom appeared? _____
   Day / Month / Year

3. Please state the symptoms of the Critical Illness Condition and date when it first appeared.

Date (Day/Month/Year)	Symptoms

4. Date when patient was first informed of the condition: _____
   Day / Month / Year

5. If the status of the Illness is already end stage, date when patient was first informed: _____
   Day / Month / Year

6. Date you first attended to the patient for the Critical Illness Condition: _____
   Day / Month / Year

7. Please provide dates with full and exact details of diagnosis of the Critical Illness Condition.

Date	Diagnosis

8. Please describe the underlying cause/s of the Illness.
   a. _____
   b. _____
   c. _____

9. Please provide details of the laboratory/diagnostic procedures conducted.

Laboratory/Diagnostic Procedures	Results

10. Please provide details for treatments/medications given.
    a. _____
    b. _____
    c. _____

11. Please provide details on the contributory/risk factors in relation to this Critical Illness Condition (if there is any).
    a. _____
    b. _____
    c. _____

12. If the Critical Illness Condition is MYOCARDIAL INFARCTION or CEREBROVASCULAR ACCIDENT, please answer or provide details for the following:
    a. Was there a history of chest pains? ☐ **Yes** ☐ **No**
       If *Yes*, when was the onset? _____ (Day / Month / Year)
    b. Please provide the results of the cardiac enzymes: _____
    c. ECG/Echocardiogram findings: _____
    d. Is the condition directly or indirectly aggravated by (if applicable):
       i. pregnancy or childbirth? ☐ **Yes** ☐ **No**
       ii. drug or alcohol abuse? ☐ **Yes** ☐ **No**

13. If the Critical Illness condition is CEREBROVASCULAR ACCIDENT, is there evidence of a permanent neurological deficit?
    ☐ **Yes** ☐ **No**
    If **Yes**, please provide details: _____

14. If the Critical Illness condition is KIDNEY/RENAL FAILURE, please answer or provide details for the following:
    a. In your opinion, is the condition chronic or acute? _____
    b. What is the underlying cause? _____
    c. Did the patient undergo
       i. Peritoneal Dialysis? ☐ **Yes** ☐ **No** If Yes, since when? _____ (Day / Month / Year)
       ii. Hemodialysis? ☐ **Yes** ☐ **No** If Yes, since when? _____ (Day / Month / Year)
       iii. Renal Transplantation? ☐ **Yes** ☐ **No** If Yes, since when? _____ (Day / Month / Year)

15. Please provide any additional information which, in your opinion, will assist us in evaluating the claim.
    _____

Printed Name of Physician:	
PTR No.:	License No.:
Hospital/Clinic:	
Hospital/Clinic Address:	
Clinic Hours:	Clinic Tel. No.:
Mobile No.:	E-mail Address:
Signature of Physician:	Date of Signing: *(Day/Month/Year)* Place of Signing:

CLAIMS REIMBURSEMENT CHECKLIST (Must be original or Certified True Copy)

❑ Duly-accomplished Notification of Claim form (NOC)

❑ Admitting Medical history (includes detailed history of present illness; family, personal and past medical history)

❑ Discharge summary report (includes patient's course in wards, diagnostic tests requested and medications given)

Additional Requirements:

If the diagnosis is Heart Attack/Myocardial Infarction *(must be diagnosed by Internist or Cardiologist)*:
- ❑ Serial electrocardiography (ECG)
- ❑ Blood tests
- ❑ Complete clinical history

If the diagnosis is Stroke *(must be confirmed by a Neurologist)*:
- ❑ CT Scan/MRI/MRA of the brain

If the diagnosis is Cancer:
- ❑ Surgical Pathology/Histopathology Report
- ❑ Radiologic (CT Scan/MRI) results

If the diagnosis is Kidney Failure:
- ❑ Laboratory Tests/Procedures (i.e., blood test, ultrasound, etc.)

If Insured underwent Major Organ Transplant:
- ❑ Record of Operation

If diagnosis is Multiple Sclerosis *(must be confirmed by a Neurologist)*:
- ❑ Nerve Biopsy or Neural Biopsy or Electrophysiology
- ❑ Medical Records indicating the following:
  - a. Two (2) episodes of well-defined neurological abnormalities
  - b. Evidence of demyelinating lesions at more than one (1) site within the central nervous system
  - c. Multiple neurological deficits which occurred over a continuous period of at least six (6) months
  - d. Medical records showing multiple neurological deficits which occurred over a continuous period of at least six (6) months
  - e. Well documented history of exacerbations and remissions of said symptoms or neurological deficits
- ❑ CT Scan result

If diagnosis is Benign Brain Tumour:
- ❑ CT Scan or MRI
- ❑ Surgical Pathology Report

If Insured underwent Coronary Artery Bypass Surgery *(must be diagnosed by a Cardiologist or Cardiovascular Surgeon)*:
- ❑ Coronary Angiography
- ❑ Record of Operation

Disclaimer:

Kindly note that the submission of the above-mentioned documents does not guarantee approval of your claim. Your claim will be reviewed and evaluated based on the available documents submitted and subject to the limits and the terms and conditions of your existing Policy.

Pacific Cross reserves the right to request for additional documents as deemed necessary.

CONTACT US

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