

EMERGENCY HOTLINE

If you are hospitalized or in need of Emergency Assistance, please get in touch with Pacific Cross Philippines.

Pacific Cross Member Hotline:

Dial Tel. No.: +63 2 8230-8511 and Press 3

Mobile No.: +63 998 964-6649 (for messaging applications such as Viber and WhatsApp)

E-mail: client_services@pacificcross.com.ph

Should you require emergency assistance, please provide the following information when you (or your authorized representative) call:

- Authorized representative's name, telephone number and relationship to the patient
- Patient's name, age, gender and employer
- Name, location and telephone number of hospital or treating doctor, if applicable

If you have concerns regarding your benefits or wish to check the status of your claim, please call the 24/7 Pacific Cross Member Hotline.

Tel. No.: +63 2 8230-8511

For claims related to Medical (In-Patient and Out-Patient) and Emergency Assistance Benefits (e.g., medical repatriation), the Attending Physician's Statement found at the last page must be filled out, signed by the Attending Physician and submitted to Pacific Cross for claims processing.

Notice of claims must be given to Pacific Cross within 30 days upon expiration of travel insurance or of completion of events for which the claim is being made. All benefits are subject to the provisions, terms and conditions of the Policy/TACTIC.

A. PARTICULARS OF CLAIMANT

First Name:			
Middle Name:		Last Name:	
Official Confirmation of Coverage (OCC) Number:			
Travel Agent/Insurance Agent (if applicable):			
Insurance Company (if covered by other Medical or Accident Insurance):			

Note: Please attach a copy of the Insurance Policy.

CONTACT DETAILS:

Home Address:		Tel. No.:	
Office Address:		Tel. No.:	
Mobile No.:		Fax No.:	
E-mail Address:			

B. AUTHORITY, RELEASE, and DECLARATION STATEMENTS

Authority: I hereby authorize Pacific Cross Insurance, Inc. and all persons duly authorized and acting on their behalf to request and receive any information or document and record from any office or entity including but not limited to airlines/carrier, travel agencies, hotels, hospital, clinic, laboratory, attending physician and other health service provider, which information or document relates to any travel and accommodation papers and other related documents, 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 & Subrogation: Any payment made by Pacific Cross or any 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.

Fraud Warning: It is understood that Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim.

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 and Travel 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 Insurance Policy.

Name of Claimant, or of Principal Insured (if Claimant is a Minor) or the Beneficiary (if the Claimant/Principal Insured is incapacitated by Illness):	
Signature of Claimant, or of Principal Insured (if Claimant is a Minor) or the Beneficiary (if the Claimant/Principal Insured is incapacitated by Illness):	
Date (mm/dd/yyyy):	

Note: For accidental death claims, or for medical claims leading to death, the signatory of this form must be the Claimant's Beneficiary.

C. Please check the appropriate box and submit the required documents to Pacific Cross. The Company reserves the right to request for additional documents as deemed necessary.

<p>BASIC CLAIMS REQUIREMENTS:</p> <ul style="list-style-type: none">• Duly accomplished Notification of Claim (NOC) Form• Copy of Travel Official Confirmation of Coverage (OCC)• Copy of Passport pages showing the dates of departure and arrival corresponding with the itinerary on the OCC• Original itinerary (e.g., itinerary or e-ticket purchased prior to the commencement of the trip)	<p><input type="checkbox"/> <u>MEDICAL AND EMERGENCY TREATMENT BENEFIT</u></p> <p>For Out-Patient Treatment</p> <ol style="list-style-type: none">1. Basic Claims Requirements2. Completely filled-out Attending Physician's Statement for Out-Patient Treatment (located on the last page of the NOC)3. Original Official Receipts of all payments made with payment details <p>If Applicable:</p> <ul style="list-style-type: none">• Photocopy of Drug prescription stating the diagnosis from the Attending Physician• Photocopy of Doctor's request for laboratory procedure• Photocopy of laboratory results
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- Photocopy of Certification from facilities (e.g., Certification Card or ID of scuba diver or accompanying scuba diver/instructor, ATV tour guide, etc.)

If Out-Patient surgical operation was done:

- Photocopy of the Operative Report (includes detailed description of surgical procedure)
- Photocopy of Histopathology Report (includes information on the nature, extent and stage of Illness which may not be seen in other documents submitted), if applicable

If Injured as a result of an Accident:

- Incident or Accident Report
- Original Police Report for vehicular Accident
- Other documents deemed necessary by the Company

For In-Patient Treatment

1. Basic Claims Requirements
2. Completely filled-out Attending Physician's Statement for In-Patient Treatment (located on the last page of the NOC)
3. Original and full Medical Report (pertaining to the Confinement) from the Hospital or Attending Physician/s (e.g., clinical abstract or admitting history, discharge summary, etc.)
4. Original Official Receipts of all payments made with payment details
5. Statement of Account (summarized and itemized) from the Hospital
6. Photocopy of the laboratory results
7. Photocopy of Doctor's prescription stating the diagnosis for home medication

If Applicable:

- Photocopy of Certification from facilities (e.g., Certification Card or ID of scuba diver or accompanying scuba diver/instructor, ATV tour guide, etc.)

If In-Patient surgical operation was done:

- Photocopy of the Operative Report (includes detailed description of surgical procedure)
- Photocopy of Histopathology Report (includes information on the nature, extent and stage of Illness which may not be seen in other documents submitted), if applicable

If Injured as a result of an Accident:

- Incident or Accident Report
- Original Police Report for vehicular Accident
- Other documents deemed necessary by the Company

☐ **HOSPITAL INCOME BENEFIT**

1. Basic Claims Requirements
2. Requirements of In-Patient Claims

☐ **BURIAL EXPENSES BENEFIT**

1. Basic Claims Requirements

2. Photocopy of the Death Certificate and relevant Coroner's Report
3. Original Official Receipts for the burial expenses incurred
4. Original Police Report (if the Accident was reported to the police authorities e.g., vehicular Accident)

☐ **PERSONAL ACCIDENT BENEFIT**

1. Basic Claims Requirements
2. Doctor's official and original written diagnosis
3. Full Medical Report establishing the loss of limb or loss of sight or total and permanent Disability or death
4. Original Police Report (if the Accident was reported to the police authorities e.g., vehicular Accident)
5. Photocopy of the Death Certificate and the relevant Coroner's Report, in case of death

☐ **PERSONAL LIABILITY BENEFIT**

1. Basic Claims Requirements
2. Original Official Receipts incurred for such liability
3. Any legal document/s establishing that payments have been made by the Insured to the injured/deceased party, in case the original Official Receipts or bills are not in the name of the Insured

If Applicable:

- Original Police Report, for other circumstances
- Other documents deemed necessary by the Company to establish legality of the claim

For Accidental Bodily Injuries to another person:

- Full Doctor's Report stating details of the Injury treated, Medicines prescribed and the services rendered
- Original Official Hospital bills and/or Statement of Account

If Death to another person shall have resulted:

- Photocopy of the Death Certificate and the relevant Coroner's Report

For Accidental Loss or Damage to another person's property:

- Certification from carrier/hotel/any other office/entity or any proof satisfactory to the Company for the accidental loss or damage to the property

☐ **LAND VEHICLE RENTAL EXCESS PROTECTION BENEFIT**

1. Basic Claims Requirements
2. Photocopy of the vehicle rental contract or agreement
3. Original Official Receipt of the rental fee and damage fee in excess of the rental company's insurance coverage
4. Original Police Report (if the Accident was reported to the police authorities e.g., vehicular Accident)

5. Original Affidavit received by the rental company stating the facts of the Accident or damage to the rented vehicle.

☐ **BAGGAGE DELAY BENEFIT**

1. Basic Claims Requirements
2. Original Baggage Irregularity Report issued by the airline or carrier
3. Original Acknowledgement Receipt or form stating the exact date and time when the baggage was retrieved

☐ **LOSS OF BAGGAGE AND PERSONAL EFFECTS BENEFIT**

1. Basic Claims Requirements
2. Original Baggage Irregularity Report issued by the airline, carrier, hotel or any party in case the loss occurred while such baggage and/or personal effects was under their custody
3. Certification or any proof satisfactory to the Company issued by the airline, carrier, hotel or any party that the lost baggage and/or personal effects was not indemnified, or Certification of Settlement specifying the amount settled
4. Original Official Receipt for the purchase of the lost baggage. If not available, submit an Affidavit for Lost Official Receipt indicating the amount, date of purchase, brand, model, and type
5. Original Official Receipts for the purchase of the lost personal effects. If not available, submit an Affidavit for Lost Official Receipt indicating the amount, brand, model, and type
6. List of items lost (baggage and personal effects), indicating the amount, brand, model, and type
7. Photocopy (unless original is requested by the Company) of the doctor's prescription for the lost Medicine

If Applicable:

- Original Police Report, for the loss of other circumstances

Note: The Company will cover the cost of the lost baggage subject to depreciation but shall not exceed the maximum benefit limit. Personal effects include clothing, prescribed Medicines, bags, footwear, etc.

☐ **DAMAGE TO BAGGAGE AND PERSONAL EFFECTS BENEFIT**

1. Basic Claims Requirements
2. Original Baggage Irregularity Report issued by the airline, carrier, hotel or any party in case the loss occurred while such baggage and/or personal effects was under their custody
3. Certification or any proof satisfactory to the Company issued by the airline/carrier/hotel or any party that the damaged baggage and/or personal effects was not indemnified, or Certification of Settlement specifying the amount settled
4. Original Official Receipt for the purchase of the lost baggage. If not available, submit an Affidavit for Lost Official Receipt indicating the amount, date of purchase, brand, model, and type

5. Original Official Receipts for the purchase of the lost personal effects. If not available, submit an Affidavit for Lost Official Receipt indicating the amount, brand, model, and type
6. List of damaged items (baggage and personal effects)
7. If already repaired, original official receipt for the cost of repair with corresponding details
8. If not repairable, Certification from a registered repair company that baggage is irreparable.

If Applicable:

- Original Police Report, for the loss of other circumstances

Note: The Company will cover the cost of the damaged baggage subject to depreciation but shall not exceed the maximum benefit limit. Personal effects clothing, prescribed Medicines, bags, footwear, etc.

☐ **LOSS OF LAPTOP BENEFIT**

1. Basic Claims Requirements
2. Original Baggage Irregularity Report issued by the airline, carrier, hotel or any party in case the loss occurred while such laptop was under their custody
3. Certification or any proof satisfactory to the Company issued by the airline, carrier, hotel or any party that the lost laptop was not indemnified, or Certification of Settlement specifying the amount settled
4. Original Official Receipt for the purchase of the lost laptop. If not available, submit an Affidavit for Lost Official Receipt indicating the amount, date of purchase, brand, model, and type

If Applicable:

- Original Police Report, for the loss due of other circumstances

☐ **THEFT OF CASH BENEFIT**

1. Basic Claims Requirements
2. Original Police Report is required in all instances

☐ **LOSS OF TRAVEL DOCUMENTS BENEFIT**

1. Basic Claims Requirements
2. Original Police Report is required in all instances
3. Original Official Receipts for the replacement fee of lost passport, unused visa and re-issuance of travel tickets of the same class
4. Photocopy of the replacement of passport, visa and re-issued travel tickets
5. Original Official Receipts for the travel and unplanned accommodation expenses

If Applicable:

- Original Itinerary, if claiming for lost travel tickets
- Original Baggage Irregularity Report issued by the airline, carrier, hotel or any party in case the documents were lost within their premise

☐ **EMERGENCY TRIP CANCELLATION BENEFIT**

1. Basic Claims Requirements
2. Proof of advance payment made for travel fare and accommodation expenses, penalties and other irrecoverable pre-paid charges related to the trip
3. Legal document proving trip cancellation with the non-refundable portion specified (e.g., Certification from Travel Agency or Tour Operator, Letter from the Airlines/Carrier, Certification from the Hotel)

If Applicable:

- Photocopy of the Death Certificate, in case of death
- Original and full Doctor's Report on the emergency medical treatment of the Insured or his Immediate Family, within the degree of relationship specified in the Policy
- Original Physician's written declaration of patient being unfit to travel
- In case of medical treatment or death of the Insured's Immediate Family, please submit the following documents:
 - Necessary Birth Certificate/s and/or Marriage Certificate/s to prove the relationship with the Immediate Family member or
 - Notarized Insured's declaration of relationship with the Immediate Family member
- Original Police Report, in case of lost travel documents
- Public documents (e.g., newspaper, magazines, etc.), online news and/or official advisory that report natural catastrophe, unexpected outbreak of strike, riot, civil commotion or sudden acts of Terrorism
- Original Irregularity Report issued by the airline, carrier, airport stating the reason of the cancellation

☐ **EMERGENCY TRIP TERMINATION BENEFIT**

1. Basic Claims Requirements
2. Proof of advance payment made for travel fare and accommodation expenses, penalties and other irrecoverable pre-paid charges related to the trip
3. Legal document proving trip termination with the non-refundable portion specified (e.g., Certification from Travel Agency or Tour Operator, Letter from the Airlines/Carrier, Certification from the Hotel)

If Applicable:

- Photocopy of the death certificate, in case of death
- Original and full doctor's report on the emergency medical treatment of the Insured or his relative within the degree of relationship specified in the Policy
- Original Physician's written declaration of patient being unfit to travel

- In case of medical treatment or death of the Insured's Immediate Family, please submit the following documents:
 - Necessary Birth Certificate/s and/or Marriage Certificate/s to prove the relationship with the Immediate Family member or
 - Notarized Insured's declaration of relationship with the Immediate Family member
- Original Police Report, in case of lost travel documents
- Public documents (e.g., newspaper, magazines, etc.), online news and/or official advisory that report natural catastrophe, unexpected outbreak of strike, riot, civil commotion or sudden acts of Terrorism
- Full and original Medical Report and original Official Receipts for the unplanned accommodation expenses, in case of Insured's Hospital discharge preventing the return to the Point of Origin as scheduled
- Original Irregularity Report issued by the airline, carrier, airport stating the reason of the cancellation

☐ **FLIGHT DELAY BENEFIT**

1. Basic Claims Requirements
2. Original Irregularity report issued by the airline, carrier, airport or the preceding bus line, shipping line or rail authority stating the reason of the delay
3. Any documentation showing actual flight taken (e.g., boarding pass, updated Itinerary, Irregularity report detailing the actual schedule)

☐ **MISSED CONNECTING FLIGHT BENEFIT**

1. Basic Claims Requirements
2. Requirements of Flight Delay Claims
3. Original itinerary for the connecting flight schedule (e.g., Itinerary or e-ticket purchased prior to the commencement of the trip)
4. Any documentation showing actual flight taken for the connecting flight schedule (e.g., boarding pass, updated Itinerary, Irregularity Report detailing the actual schedule)

☐ **STRIKES AND HIJACKS BENEFIT**

1. Basic Claims Requirements
2. Copy of the itinerary or travel ticket corresponding to the delay in reaching the destination
3. Original Incident Report or Certification from the airline, carrier, public conveyance that a strike or hijack occurred

☐ **ALTERNATIVE MEANS OF TRANSPORTATION BENEFIT**

1. Basic Claims Requirements
2. Original Irregularity Report issued by the airline, carrier, airport stating the reason of the cancellation or delay
3. Any documentation showing actual flight taken (e.g., boarding pass, updated Itinerary or Irregularity Report detailing the actual schedule)

4. Original alternative public transport Itinerary with payment details and/or original Official Receipt of the alternative public transport expenses

☐ **TRIP POSTPONEMENT BENEFIT**

1. Basic Claims Requirements
2. Original Irregularity Report issued by the airline, carrier, airport stating the reason of the cancellation or delay
3. Any documentation showing actual flight taken (e.g., boarding pass, updated Itinerary or Irregularity Report detailing the actual schedule)
4. Proof of advance payment made for travel fare and accommodation expenses, penalties and other irrecoverable pre-paid charges related to the postponed trip
5. Legal document proving trip postponement with the non-refundable portion specified (e.g., Certification from Travel Agency or Tour Operator, Letter from the Airlines/Carrier, Certification from the Hotel)

DISCLAIMER:

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

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

NOTES:

- If the documents presented are written in a language other than Filipino or English, the appropriate translation fee will be deducted from the approved claim amount. All sections of the NOC must be completed. Please write legibly.
- If space is insufficient, please attach details on separate sheet. Additional copies of this form are available upon request from Pacific Cross. You may also photocopy this form as needed.

D. Please give a short description of the circumstances giving rise to your claim. If space is insufficient, please attach additional details.

BENEFIT:	
DETAILS:	

BENEFIT:	
DETAILS:	

E. OFFICIAL RECEIPTS SUBMITTED (If space is insufficient, please attach additional details.)

Official Receipt Number	Details of Payment (professional fees, medicines, baggage, burial expenses, etc.)	AMOUNT		
		PHP	USD	Other pls. specify currency
TOTAL		PHP	USD	

F. CLAIMS PAYMENT DETAILS

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

<input type="checkbox"/>	DIRECT CREDIT TO MY NOMINATED BANK ACCOUNT			
<input type="checkbox"/> BDO	<input type="checkbox"/> Metrobank	<input type="checkbox"/> BPI	<input type="checkbox"/> Eastwest	<input type="checkbox"/> UnionBank
<input type="checkbox"/> Other Banks				
Bank and Branch of Account:				
Account Name:				
Account No.:				
Account Type:		<input type="checkbox"/> S/A <input type="checkbox"/> C/A		
SWIFT Code:				
Account Holder's Address:				

For Dollar and Euro Policies, please indicate preferred currency of transfer:	
<input type="checkbox"/> Peso	<input type="checkbox"/> Dollar (for those with USD Bank accounts only)
Bank and Branch of Account:	
Account Name:	
Account No.:	
Account Type: <input type="checkbox"/> S/A <input type="checkbox"/> C/A	
SWIFT Code:	
Account Holder's Address:	
Notes: <ol style="list-style-type: none">Whenever applicable, cost of interbank/interbranch crediting will be deducted from the approved claim amount.In some cases, nominated banks may deduct fees from the approved claim amount.A processing fee of PHP 100.00 will be deducted from your claim resulting from the incorrect information provided by claimant.	

<input type="checkbox"/>	GCASH
<input type="checkbox"/>	If you already have a GCash Card registered to Pacific Cross, please provide the following details:
Account Name:	
Account Number:	
<input type="checkbox"/>	If you do not have a GCash Card registered to Pacific Cross yet, please fill out a GCash Registration Form. You may request a copy from our Customer Service Team, or download it from our website.

ATTENDING PHYSICIAN'S STATEMENT				
<input type="checkbox"/> OUT-PATIENT	Date of Consultation:			
<input type="checkbox"/> IN-PATIENT	Date Admitted:		Time:	
	Date Discharged:		Time:	
(A) Diagnosis/es	(B) Date when symptoms first appeared	(C) Date when patient was diagnosed with the condition	(D) Previous treatment done for the symptom/diagnosis	
			Treatment Date	Name of Doctor and Hospital
1.				

2.				
3.				
4.				

(E) Reason for admission:				
(F) If condition is a complication, date when symptoms of its cause started (mm/dd/yyyy):				
(G) Name of Surgical Intervention (if any):				
Any required post operative consultations?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate consultation date/s:		
(H) Any other disease or infirmity affecting present condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please describe:				
(I) Is condition due to Dental problem, Pregnancy, Childbirth, Miscarriage or Sickness originating there from?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please state the cause:				
(J) Is the diagnosis in any way related to the ff: congenital/heredofamilial conditions/developmental abnormalities/birth defects/obesity?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
(K) Do you consider this consultation as a continuous treatment for a chronic disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
(L) Is this a Routine General Medical Examination or Vaccination?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
(M) Is this condition accident-related?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when did the accident happen?		Around what time:
What was the nature of the accident?				
(N) Is Physiotherapy recommended?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
(O) For Out-Patient: Is the condition related to a previous confinement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate confinement date/s:		

Name of the Main Attending Physician/Surgeon:	
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Signature of the Main Attending Physician/Surgeon:	
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Hospital:		Tel. No.:	
Address:		Fax No.:	

Note: You may photocopy this form as needed.