NOTIFICATION OF CLAIM – NON-AIR DOMESTIC TRAVEL INSURANCE

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

IMPORTANT! PLEASE READ!

If you have concerns regarding your benefits or wish to check the status of your claim, please call Pacific Cross Customer Service.

Tel. No.: +63 2 8899-8001 locals 2302 and 2303; Mondays to Fridays, from 8:30 a.m. to 5:30 p.m.
For claims related to Medical (In-Patient & Out-Patient) Benefits, the Attending Physician Statement found at the back of this page must be filled out, signed by the Attending Physician and submitted to Pacific Cross for claims processing.

- A duly accomplished Notification of Claim Form must be submitted along with appropriate requirements to begin processing of your claim.
- 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.
- For all claims, the original Non-Air Domestic Official Confirmation of Coverage (NADOCC) must be submitted. For photocopy of death certificate, please bring original for presentation purposes.
- Please submit required documents as indicated on the Claims Requirements Reimbursement Checklist. The Company reserves the right to request for additional documents as deemed necessary.
- 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 the Master Policy.
- All sections of the NOC must be completed. Please write legibly. If space is insufficient, please attach additional details on a separate sheet.
- Additional copies of this form are available upon request from Pacific Cross. You may also photocopy this form as needed.

A. PARTICULARS OF CLAIMANT

First Name:			
Middle Name:		**Last Name:**	
Non-Air Domestic Official Confirmation of Coverage Number (NADOCC) Group Policy 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:

Address:		**Tel. No.:**	
E-mail Address:		**Mobile No.:**	

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 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 & 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.

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 Patient is a Minor) or the Beneficiary (if the Patient/Principal Insured is incapacitated by illness):	
Signature of Claimant or of Principal Insured (if Patient is a Minor) or the Beneficiary (if the Patient/Principal Insured is incapacitated by illness):	

Date of signing (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. CLAIMS REIMBURSEMENT CHECKLIST

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.

☐ **MEDICAL AND EMERGENCY BENEFIT**

- **For Out-Patient Treatment**
  - Completely filled out Attending Physician's Statement for Out-Patient Treatment
  - Original official receipts with payment details
  - If with surgical operation, photocopy of the operative report
  - Photocopy of doctor's prescription of medication required for treatment
  - Photocopy of doctor's request for laboratory procedure
  - Photocopy of laboratory results
  - If accident related, original police report/accident report

- **For In-Patient Treatment**
  - Original and full medical report (pertaining to the confinement) from the hospital or attending physician/s (e.g. clinical abstract/admitting history, discharge summary, etc.)
  - Original itemized statement of account from the hospital
  - Original official receipts with payment details
  - If with surgical operation, photocopy of the operative report
  - Photocopy of the laboratory results
  - Photocopy of doctor's prescription for home medication
  - If accident related, original police report/accident report
  - Completely filled out Attending Physician's Statement for In-Patient Treatment

☐ **PERSONAL ACCIDENT BENEFIT**

- Doctor's official and original written diagnosis
- Full medical report establishing the loss of limb or loss of sight or total and permanent disability.
- In case of death, a photocopy of the death certificate and the relevant coroner's report
- If the accident was reported to the police authorities, original police report

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

Official Receipt Number	Details of Payment (professional fees, medicines, hospital bill)	Amount (PHP)

TOTAL PHP

E. CLAIMS PAYMENT DETAILS

(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 (except Rural Banks)

Bank and Branch of Account:	
Bank Address:	
Account Name:	
Account No.:	
Account Type:	☐ S/A ☐ C/A
SWIFT Code:	
Account Holder's Address:	

PLEASE INDICATE PREFERRED CURRENCY OF TRANSFER:

☐ Peso ☐ Dollar (for those with USD Bank accounts only)

Bank and Branch of Account:	
Bank Address:	
Account Name:	
Account No.:	
Account Type:	☐ S/A ☐ C/A
SWIFT Code:	
Account Holder's Address:	

Notes:

1. Whenever applicable, cost of interbank/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 PHP100.00 will be deducted from your claim resulting from the incorrect information provided by claimant.

☐ **GCASH**

☐ If you already have a GCash Card registered to Pacific Cross, please provide the following details:

Account Name:	
Account No.:	

☐ 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

☐ **OUT-PATIENT**	Date of Consultation:			
☐ **IN-PATIENT**	Date Admitted:		Time:	
	Date Discharged:		Time:	

(A) Diagnosis/es	(B) Date when symptoms first appeared	(C) Date of first consultation for the condition	(D) Previous treatment done for the symptom/diagnosis	
			Treatment Date	Name of Doctor & Hospital
1.				
2.				
3.				
4.				

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

Name of the Main Attending Physician/Surgeon:	
Signature of the Main Attending Physician/Surgeon:	
Date of signing (mm/dd/yyyy):	

Hospital:		**Tel. No.:**	
Address:		**Fax No.:**	