BENEFIT AVAILMENT GUIDELINES

for
SELECT PREPAID INSURANCE PLANS

What's Inside:

- Select Prepaid Insurance Benefit Overview
- Availment Procedures
- Reimbursement Claims Procedure
- Claims Requirements

PACIFIC CROSS

Please call our Customer Service Hotline at +63 2 8230-8511 or
E-mail client_services@pacificcross.com.ph for more details.

Getting in touch with us

It is important for you to know how to access medical treatment. This booklet will provide these essential pieces of information. However, as we understand that it is easier to call or e-mail us to obtain assistance or to get answers to your specific questions, we have formed quick response teams to handle specific concerns. These teams are outlined below.

Directory of Important Information
CLIENT HOTLINE
Tel. No.: +63 2 8230-8511
client_services@pacificcross.com.ph
Call or email Us if you have concerns about: • The benefits and limitation of your plan with us • The status of your claim; or • The availment procedures • The registration and activation of your Select Prepaid Insurance Plan *Available 24/7*
www.pacificcross.com.ph
For downloadable forms and brochures or to check on the accredited providers network list.

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Definition of Terms

ACCREDITED NETWORK: A group of Physicians, Dentists, including Specialists like Surgeons and Cardiologists, Hospitals and Clinics with an agreement with the Company or Company's subsidiary (Pacific Cross Health Care, Inc.) to provide services to the Insured Person of the Company. The Company pays directly to the accredited network for valid benefit availment of the Insured Person

EMERGENCY: A condition wherein the Insured Person is in severe pain or suffers serious Illness or Injury that requires immediate medical or surgical attention which, if not rendered, may result in loss of a vital function of the body such as the loss of limb or eyesight, or the loss of life.

HOSPITAL: An institution which is legally licensed as a medical or surgical Hospital in the country where it is located and whose main activities are not those of a spa, hydro-clinic, sanitarium, nursing home, home for the aged, a place for alcoholics or drug rehabilitation. It must be under the constant supervision of a resident Physician.

CONFINEMENT: A continuous stay for a period of not less than 18 hours as a registered bed patient in a Hospital required by a Physician for treatment of a covered Illness or Injury.

INSURED PERSON: Are those persons specifically listed and named in Schedule 2 of the Policy

Refers to a person whom the Medical Prepaid Card was registered;

Availment Mode

SELECT ER

Gives you the option to avail of no-cash-outlay emergency out-patient treatment using our accredited network of hospitals, or file your eligible claims for reimbursement in the event that you choose not to go to an accredited medical provider.

SELECT DENGUEGUARD

Enjoy cash assistance worth PHP 10,000 for medically diagnosed Dengue.

SELECT MEDSECURE

Avail of one-time reimbursement for the actual amount of prescribed medicines, vitamins and supplements of the Insured Person as part of a follow-up care within 90 days post hospitalization.

Your Medical Prepaid Insurance

SELECT ER BENEFIT OVERVIEW

Enjoy cashless medical treatment or cash assistance worth PHP 5,000 and PHP 20,000 (depending on the card variant bought) for emergencies due to illness or accident.

SELECT DENGUEGUARD BENEFIT OVERVIEW

Receive cash assistance worth PHP 10,000 for medically diagnosed Dengue. No hospitalization required.

SELECT MEDSECURE BENEFIT OVERVIEW

Reimburse up to PHP 2,000 worth of prescribed medicines post-hospitalization.

Availment Procedures (Within the Accredited Network)

CASHLESS EMERGENCY OUT-PATIENT TREATMENT

(1) Insured Person to proceed to an accredited hospital's E.R. Department.

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(2) Insured Person to present an SMS or E-mail confirmation from their mobile phones and a valid identification card for verification purposes. If no proof of coverage or any message confirmation from PACIFIC CROSS, Insured Person to inform the hospital personnel that you are availing under PACIFIC CROSS and to call PACIFIC CROSS for verification and for manual approval request

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(3) PACIFIC CROSS to conduct policy and benefit verification upon receipt of call from the hospital personnel.

Once verified, PACIFIC CROSS to provide manual approval and coverage limit to the hospital personnel and to also inform that if the emergency out-patient availment leads to confinement, manual approval provided will be voided.

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(4) The E.R. staff on duty will attend to the Insured Person and conduct treatment and/or laboratory tests.

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(5) The Insured Person must sign necessary documents.

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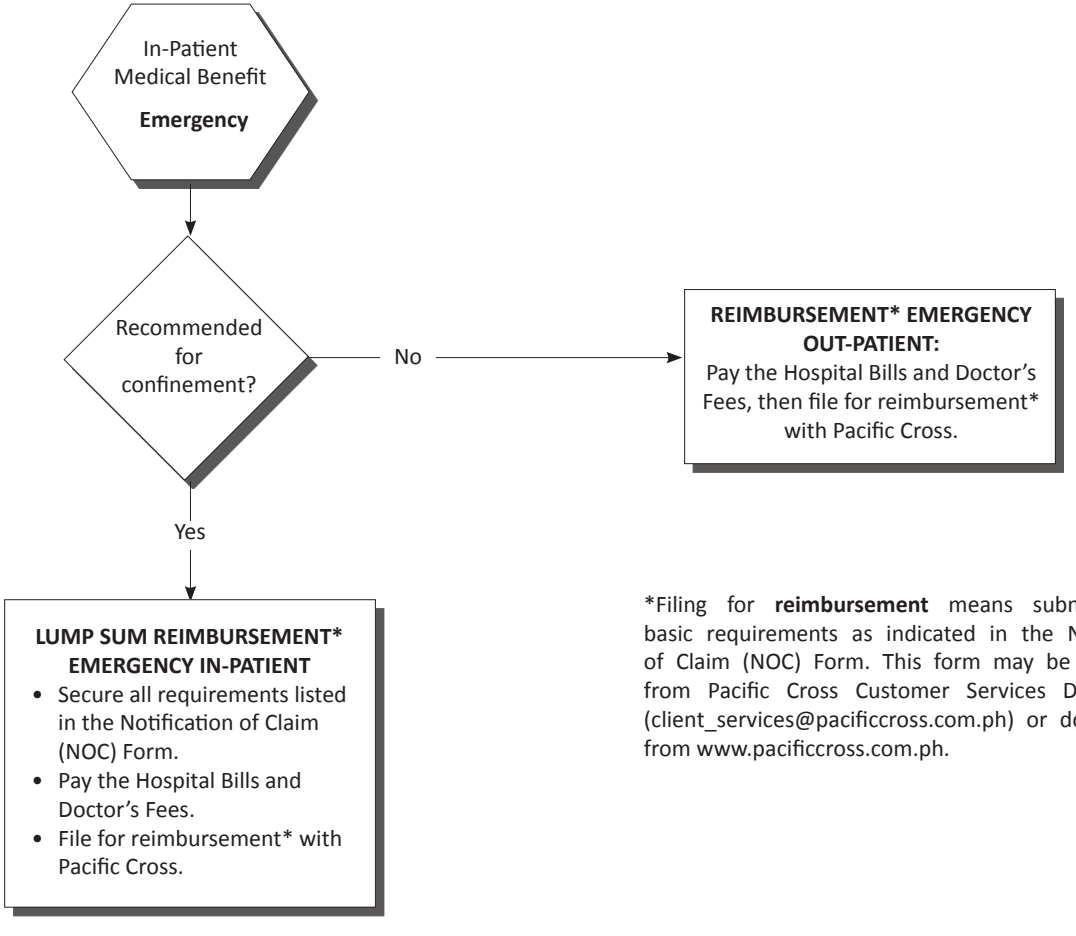
(6) The Insured Person will be discharged upon settlement of any amount in excess of the E.R. benefit limit at the hospital cashier.

Reimbursement Claims Procedure

REIMBURSEMENT EMERGENCY IN-PATIENT AND OUT-PATIENT TREATMENT



*Filing for **reimbursement** means submission of basic requirements as indicated in the Notification of Claim (NOC) Form. This form may be requested from Pacific Cross Customer Services Department (client_services@pacificcross.com.ph) or downloaded from www.pacificcross.com.ph.

Claims Requirements

Always include an NOC each time you file a claim.

PACIFIC CROSS

NOTIFICATION OF CLAIM - MEDICAL PREPAID CARD

☐ Select DengueGuard ☐ Select MedSecure ☐ Select Assist

☐ Select ER (☐ Out-Patient ☐ In-Patient) ☐ Others _____

Please write legibly and use block letters whenever possible.

ALL SECTIONS MUST BE COMPLETELY FILLED OU

A. PATIENT'S INFORMATION

Patient's Name: **Stephanie K. Villarica**

Address: **No.25, YMCA Village, Nagoya St. Fairview, Quezon City**

Tel. No.: **936-8686** Mobile No.: **(0927) 555-7231** E-mail Address: **stephanievillarica@gmail.com**

Patient's Date of Birth (dd/mm/yy): **10/12/1980** Age: **33** Gender: ☐ Male ☑ Female

If claiming under group account, Company/Employer's Name: _____

Describe the illness, injury, or symptom leading to consultation with your doctor: **Motor Vehicular Accident**

B. AUTHORITY, RELEASE, and DECLARATION STATEMENTS

Authority: I hereby authorize 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 & 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. 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.

Non-Waiver Clause For Express Claims: It is understood that the examination/evaluation of the above claim and payment thereof is purely based on the Company's liberality and gesture of promptly and religiously paying the said claim but subject to the condition that any and all future claims arising out of the same condition on the fast-tracked claims should be subject to the Terms and Conditions of the Policy (i.e., limits of the liability, general exclusion, pre-existing conditions, concealed conditions) and the Company, therefore reserves the right to require the Insured to submit documentary proofs in connection thereof.

It is furthermore understood that any payment of a fast-tracked claim shall not be construed as a waiver by the COMPANY to determine the compensability or non-compensability of subsequent/future claims covering the same condition for the fast-tracked claims paid.

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 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.

Stephanie Villarica
Signature over Printed Name of Patient or of Principal Insured (if Patient is a Minor) or the Beneficiary (if the Patient/Principal Insured is incapacitated by illness)

2/14/2014
Date

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

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

Official Receipt Number	Details of Payment (professional fees, medicines, laboratory exams, etc.)	Amount		
		PHP	USD	Others. Pls. specify currency.
1245	Wound suture	2,500		
102281	Emergency Room Fee	1,200		
010256758	Celebrex	500		
15725	CT scan	3,400		
	TOTAL	7,600		

Please provide a breakdown of the documents you submitted.

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: Fairview

Bank Address: No.25, YMCA Village, Nagoya St. Fairview, Quezon City

Account Name: Stephanie Villarica

Account No.: SA # 18874 2560 19

Account Type: ☑ S/A ☐ C/A

SWIFT Code: _____

Account Holder's Address: _____

Tell us how you want to receive your claims payment.

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.

TO BE COMPLETED BY THE MAIN ATTENDING PHYSICIAN/SURGEON ONLY

NOTIFICATION OF IN-PATIENT CLAIM

1. Admitted FROM: _____ TO: _____
2. Complete diagnosis/es of medical condition(s): Month and year when symptoms first appeared:
   a. _____ _____
   b. _____ _____
   c. _____ _____
   d. _____ _____
3. Reason for admission: _____
4. When did the patient first consult you on his/her condition? _____
5. If it is a complication, when did the symptoms of its cause start? _____
6. Did the patient's condition require surgery? ❑ Yes ❑ No
   If yes, please state: Name of surgical procedure involved: _____
   Number of in-patient to bedside visits (visits/days): _____
7. Is the condition accident-related? ❑ Yes ❑ No
   If yes: When did the accident happen? _____ At around what time? _____
   What was the nature of the accident? _____
8. Maintenance medication prior to first consult: _____

Whenever possible, request your attending physician to accomplish and sign the NOC. However, should this not be possible, we will refer to the medical certificate and other documents you submitted.

_____
Signature over Printed Name of the Main Attending Physician/Surgeon

Physician's Address: _____
Physician's Tel. No.: _____

NOTIFICATION OF OUT-PATIENT CLAIM

1. Complete diagnosis/es of medical condition(s): Month and year when symptoms first appeared:
   a. **Motor Vehicular Accident** **February 08, 2014**
   b. _____ _____
   c. _____ _____
   d. _____ _____

   Name of surgical procedure involved: _____ Place where surgery was performed: _____
2. When did the patient first consult you on his/her condition? _____
3. Is the condition accident-related? ❑ Yes ☑ No
   If yes: When did the accident happen? _____ At around what time? _____
   What was the nature of the accident? _____
4. Is the illness or injury related to the patient's employment? ❑ Yes ☑ No
   If yes, state reason(s): _____
5. Is the illness or injury related to a previous confinement? ❑ Yes ☑ No
   If yes, please indicate confinement date: _____
6. Is the condition maternity related? ❑ Yes ☑ No
   If yes: Patient is pregnant for _____ weeks at consultation.
7. Indicate maintenance medication prior to first consult: _____

Dr. Josefina Parla - Santos
Signature over Printed Name of the Main Attending Physician/Surgeon

Physician's Address: **Makati Medical Center, Room 2410**
Physician's Tel. No.: **858-6722**

REMINDER TO PATIENT:

Please refer to back portion (Claims Reimbursement Checklist) for other documents required in filing a claim.

CLAIMS REQUIREMENTS CHECKLIST

I. FOR DENGUEGUARD

BASIC REQUIREMENTS:

- ❑ Duly-accomplished Notification of Claim (NOC) form
- ❑ Medical Certification with diagnosis of confirmed dengue from any licensed medical facility where you had your consultation or treatment
- ❑ (+) Dengue (Dengue NS-1 or Dengue Duo test(Immunoglobulin G and Immunoglobulin M) tests result

II. FOR MEDSECURE

BASIC REQUIREMENTS:

- ❑ Duly-accomplished Notification of Claim (NOC) form
- ❑ Discharge Summary Report with diagnosis and confinement period or Clinical Abstract with diagnosis and confinement period or Medical Certificate stating the diagnosis with confinement period and the corresponding Statement of Account with Room and Board charges
- ❑ Discharge Instruction with a list of prescribed take-home medicines
- ❑ Drug prescription from the Attending Physician
- ❑ Copy of Official Receipt for the purchased medicines

For injury as a result of an accident:

- ❑ Basic requirements for MedSecure claims
- ❑ Copy of police report
- ❑ Incident report

For Out-patient follow-up care consultation within 90 days immediately following the discharge from Hospital Confinement

- ❑ Medical Certificate Stating the consultation is related to the previous confinement with the diagnosis
- ❑ Drug prescription from the attending physician
- ❑ Copy of Official Receipt for the purchased medicines

III. FOR SELECT ER

EMERGENCY OUT-PATIENT TREATMENT:

BASIC REQUIREMENTS:

- ❑ Duly-accomplished Notification of Claim (NOC) form
- ❑ Emergency Medical Certificate
- ❑ Official Receipts
- ❑ Statement of Account
- ❑ Copy of laboratory and diagnostic test result/s, if any

EMERGENCY IN-PATIENT TREATMENT:

BASIC REQUIREMENTS:

- ❑ Duly-accomplished Notification of Claim (NOC) form
- ❑ Admitting Medical History
- ❑ Discharge Summary Report or Clinical Abstract stating the final diagnosis and confinement date
- ❑ Statement of Account reflecting room and board charges

For injury as a result of an accident:

- ❑ Basic requirements for Select Emergency Out-Patient or Emergency In-Patient Claims
- ❑ Copy of police report
- ❑ Incident report

Always review the checklist before submitting your claim to make sure you've given us all the required documents.

IV. FOR SELECT ASSIST

BASIC REQUIREMENTS:

- ❑ Duly-accomplished Notification of Claim (NOC) form
- ❑ Admitting Medical History
- ❑ Discharge Summary Report or Clinical Abstract stating the final diagnosis and confinement date
- ❑ Statement of Account reflecting room and board charges

For injury as a result of an accident:

- ❑ Basic requirements for Select Assist claims
- ❑ Copy of police report
- ❑ Incident report

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 available documents submitted and subject to the limits and the terms and conditions of your existing Agreement.

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

HEAD OFFICE
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For further details, please contact:

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We also have Agency Offices in:

Luzon: Cavite | Laguna | Makati | Manila | Naga | Pampanga | Pasig | Taguig

VisMin: Bacolod | Bohol | Butuan | Cagayan de Oro | Dumaguete | General Santos

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