

BLUE ROYALE MEDICAL PLAN PACIFIC CROSS **APPLICATION FORM** Pacific Cross Insurance, Inc. BR Plan B BR Plan C BR Plan A Application Reference No.: Directions: Please answer this application form as truthfully as possible. All sections must be completed using a ballpen or signpen. Please use block letters. Application forms without the appropriate signatures and dates will be returned. This form is valid for forty five (45) days from the date of your application.

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INSURANCE TYPE: Individual _	Family		
PERSONAL INFORMATION:	Principal Applicant		2 2 4 4
FIRST NAME:			2 x 2 photo of Principal Applicant
MIDDLE NAME:	LAST NAME:		, pp. iod. it
MOTHER'S MAIDEN NAME:			
BIRTHDATE: day yea	PLACE OF BIRTH	NATIONALITY:	
CIVIL STATUS: Single Married	d Widow/Widower Separated	SEX: Male Female WEI	GHT: lbs. HEIGHT: ft. in.
OCCUPATION:	NATURE OF WORK	((Administration, Sales, etc.):	
NAME OF EMPLOYER:	If s	self-employed, nature of business:	
SOURCES OF FUNDS OR PROPERTY	: Salary Business	Others (Pls. specify:)
GOV'T ISSUED CARD: Passport	TIN SSS GSIS Driver	's License Others (Pls. specify:) No.:
entrusted with appointive or elective position in	r (within the second degree of consanguinity or a n the Philippines or in a foreign state, a senior po overnment or state-owned or controlled corporat Name	litician, No Yes (Name/Po	osition/Public Office:)
BENEFICIARY:		Situates (illing asijyyyy)	1 11
PLACE OF BIRTH:	CONTACT NUMBER:	SEX: Male Female	NATIONALITY:
ADDRESS:			
GOV'T ISSUED CARD: Passport CONTACT INFORMATION		's License Others (Pls. specify:) No.:
PERMANENT ADDRESS (Home Co (Number, Street, Block, Subdivision	n, City, Zip Code, Province, Country))	
PRESENT ADDRESS (Country of Re RESIDENCE (Number, Street, B	esidence*): lock, Subdivision, City, Zip Code, Pro	ovince, Country)	
BUSINESS (Number, Street, Blo	ock, Subdivision, City, Zip Code, Prov	rince, Country)	
*Must be the Insured's place of reside unless otherwise declared and covered E-MAIL ADDRESS:	nce or place of employment for not less than d by an Endorsement to the Policy.	six (6) months within the Period of Insuran	ce. It is deemed to be the Philippines
*This e-mail address will be used for sending you CONTACT DETAILS:	r policy documents which may include sensitive med	lical information. Your membership card and all po	olicy documents will be sent to you by e-mail.
Residence Tel. No.:	Business Tel. No.:	Fax No	o.:
Mobile No.:	Alternate Mobile No.:	Alternate E-mail Addre	ss:
For Internal Use Only —			
SELLER'S DETAILS		Date Recei	ved:
DIRECT (AE's ID No.:) INTERMEDIA	RY If Broker, name of Company: If Agent, name of Agent:	
PRODUCT and PLAN DETA	LS	Broker/Agent Code:	
Effectivity Date: (mm/dd/yyyy)			REMARKS:
New Applicant Addition	al Applicant 🔲 Re-Application 🔲	Take-Over Account Transfere	e
State insurance company/HMO	(If a Take-Over Account):		

For Single Applicant - Please state names of parents first, followed by siblings (from eldest to youngest). For Married Applicant - Please state name of spouse first, followed by children (from eldest to youngest). If there are more than three (3) dependents, please use additional copies of this form.

DEPENDENT 1 (i.e., Spouse or Parent) Relationship to Principal Applicant:
FIRST NAME: MIDDLE NAME:
LAST NAME: BIRTHPLACE:
PRESENT ADDRESS: (if different from Principal Applicant)
E-MAIL ADDRESS: RESIDENCE TEL. NO.: MOBILE NO.: BIRTHDATE: mm/dd/yyyy
SEX: Male Female NATIONALITY: WEIGHT: lbs. HEIGHT: ft. in.
GOV'T ISSUED CARD: Passport TIN SSS GSIS Driver's License Others (Pls. specify:) No.:
OCCUPATION: NATURE OF WORK (Administration, Sales, etc.):
NAME OF EMPLOYER: [If self-employed, type of industry: [[]
Name Date of Birth (mm/dd/yyyy) Place of Birth Relationship to Dependent 1 Contact Number
ADDRESS: SEX: Male Female NATIONALITY:
GOV'T ISSUED CARD: Passport TIN SSS GSIS Driver's License Others (Pls. specify:) No.:
DEPENDENT 2 Relationship to Principal Applicant:
FIRST NAME: MIDDLE NAME:
LAST NAME: BIRTHPLACE:
PRESENT ADDRESS: (if different from Principal Applicant)
E-MAIL ADDRESS: RESIDENCE TEL. NO.: MOBILE NO.: BIRTHDATE: mm/dd/yyyy
SEX: Male Female NATIONALITY: WEIGHT: Ibs. HEIGHT: ft. in.
GOV'T ISSUED CARD: Passport TIN SSS GSIS Driver's License Others (Pls. specify:) No.:
OCCUPATION: NATURE OF WORK (Administration, Sales, etc.):
NAME OF EMPLOYER: (if applicable) If self-employed, type of industry:
Name Date of Birth (mm/dd/yyyy) Place of Birth Relationship to Dependent 2 Contact Number BENEFICIARY:
ADDRESS: SEX: Male Female NATIONALITY:
GOV'T ISSUED CARD: Passport TIN SSS GSIS Driver's License Others (Pls. specify:) No.:
DEPENDENT 3 Relationship to Principal Applicant:
FIRST NAME: MIDDLE NAME:
LAST NAME: BIRTHPLACE:
PRESENT ADDRESS: (if different from Principal Applicant)
E-MAIL ADDRESS: RESIDENCE TEL. NO.: MOBILE NO.: BIRTHDATE: mm/dd/yyyy
SEX: Male Female NATIONALITY: WEIGHT: Ibs. HEIGHT: ft. in.
GOV'T ISSUED CARD: Passport TIN SSS GSIS Driver's License Others (Pls. specify:) No.:
OCCUPATION: NATURE OF WORK (Administration, Sales, etc.):
NAME OF EMPLOYER: If self-employed, type of industry:
Name Date of Birth (mm/dd/yyyy) Place of Birth Relationship to Dependent 3 Contact Number
ADDRESS: SEX: Male Female NATIONALITY:
ADDITESS.
GOV'T ISSUED CARD: Passport TIN SSS GSIS Driver's License Others (Pls. specify:) No.:

DIRECTIONS: Please tick YES or NO to every question for each person to be insured.		lame of licant	First Name of Dependent 1		First Name of Dependent 2		First Name of Dependent 3	
	YES	NO	YES	NO	YES	NO	YES	NO
1. Are you currently covered under PhilHealth?								
2. a. Are you currently covered by any medical policy?				$\overline{}$				
(Please include a copy of the policy and benefit schedule.)								
b . Has any of your medical or life application been declined, rated or restricted?								
c. Has any of your medical or life policy been cancelled, withdrawn, rated or								
restricted? 3. Have you ever been, or are you currently a smoker? If YES:								
a. How long have you been a smoker?		ears		years	│	/ears	│	/ears
b. If still a smoker, how many cigarette sticks per day?		g. sticks		ig. sticks		ig. sticks		ig. sticks
c. If no longer a smoker, provide no. of years since you last smoked.		ears	I	years		ears/		ears/
4. Do you engage in any form of sports? If YES, please specify.								
If you tick YES to any of the questions, please provide DETAILS OF YES RESPONSES a	and attac	h the cor	resnondi	ng MFDI	 ΔΙ REPC	RTS indi	rated on	nage 4
Please ensure that you tell us about all your medical conditions and symptoms, wh professional advice was sought. If you were previously or already are a Pacific Cross F as a new business under any Pacific Cross products, please include details of any cor	nether pa Policyholo	st and/or der and ye	r present, ou are ap	known plying to	and/or su increase	uspected, cover or	, whethe you are a	r or not pplying
5. At any given time, have you had symptoms of or been diagnosed or treated								
for any:		_						_
a. speech defect, paralysis, hearing loss, physical or birth defect, infirmity,								
congenital/hereditary illness or chronic condition?								
b. ear discharge, nose bleeds, double vision, impaired sight, respiratory or allergic condition or disorder of the eye, ear, nose or throat?								
c. mental disorder (disease of the brain), nervous disorder, stroke, seizure or fit,								
weakness, swelling or dislocation of a limb, prolonged headache, blackout,								
fainting, mood change, sleep disorder/insomnia, drug/alcohol addiction?								
d. blood pressure problem, chest pain, cholesterol problem, dizziness,								
anemia, heart murmur, breathlessness, abnormal heart rate, rheumatic								
fever, varicose veins, heart or circulatory disorder?								
e. jaundice, hepatitis of any form, gall/kidney stone, venereal disease, or disorder								
of the bladder/urination, prostate, kidney, genitourinary tract or pancreas?	_	_	_	_	_		_	_
f. Indigestion, gastritis, ulcer, blood in stools, fistula, hernia, hemorrhoid,								
colitis or stomach, liver or bowel disorders?	_		_	_	_	_	_	
g. back or neck pain or strain, spinal condition, sciatica, slipped disc, whiplash,								
gout, bone fracture, joint pain or joint injury (e.g., knee, elbow, wrist,								
shoulder), hallux valgus (hammer toes), muscle disorder, arthritis, joint								
or bone disease?								
h. HIV, AIDS/AIDS Related Complex or any indication of blood or immune								
system connective tissue disorder?								
i. any form of cancer, mass, lump, cyst, tumor or growth of any kind?		<u> </u>						_ <u> </u>
j. psoriasis, eczema, dermatitis, acne or any other skin condition?k. hormone, endocrine or glandular disorder or condition like:								
k1. diabetes								
k2. thyroid (ex: goiter)/parathyroid disorder								
k3. obesity								
k4. endocrine tumors								
k5. others (Please specify)?								
I. (for females only) complications of pregnancy, pregnancy-related disease,								
abnormal smear test or any gynecological/menopausal disorder (e.g.,								
fibroid) and/or cyst of the female reproductive system?								
6. Have you ever been prescribed or recommended, underwent, or are currently taking								
any medication or treatment? (Please list dosage and other details on next page.)			_					
7. Have you been a patient (as out-patient or in-patient) in a hospital, clinic or								
sanitarium at any given time?								
8. Have you undergone or been advised to have any medical test or procedure								
other than as noted above? (Please provide details on next page.)								
9. Is there any accident, injury, illness, disease, condition, ailment, impairment,								
medical investigations, or hospital treatments not mentioned above?								
10. Are there additional pages forming part of your declarations that are attached to this Application Form?							📙	
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If space is insufficient, you may use additional sheets of paper with your signature. To ensure that sufficient information is received for our timely and complete assessment, each item containing the details of YES responses must be supported with the corresponding medical reports to be submitted together with this application form.

Qstn Med No. Cond		Nature/Date of Treatment	Current Status	Doctor's Name	Doctor's Current Info (Address, Phone No., Fax No.)
Name of Principal A	pplicant:				
Attachments:	5		Remarks:		
Medical test resultsMedical certificate	☐ Utilization/ ☐ Others:	•			
Name of Dependen	t 1:				
Attachments:			Remarks:		
☐ Medical test results ☐ Medical certificate	☐ Utilization/☐ Others:				
Name of Dependen					
Name of Dependen	ι Ζ.				
Attachments:			Remarks:		
☐ Medical test results	☐ Utilization/o				
☐ Medical certificate	Others:				
Name of Dependen	t 3:				
Attachments: Medical test results	☐ Utilization/	claims roport	Remarks:		
☐ Medical certificate	Others:				

I understand that failure to answer truthfully the questions in this application, or concealment, or misrepresentation of any significant condition will result in the voiding of all the applicable insured's benefits under the plan. I also understand that this application may be returned to me if I fail to complete all details requested.

I understand that this application form and all test results are subject to medical evaluation. I understand that a premium loading may be applied subject to the results of the medical evaluation. I understand that Pacific Cross Insurance, Inc. reserves the right to decline application for coverage based on the results of the medical evaluation.

I certify that I am informed of the benefits, exclusions and all other provisions of the Policy.

I certify that I am informed and have understood the meaning of PRE-EXISTING CONDITIONS and MEDICAL EXCLUSIONS.

- Pre-Existing Conditions declared to the Company and have been included by an Endorsement are covered according to the terms specified therein. It shall only be covered provided that there is no failure to disclose, misrepresent or conceal material information. Every year upon renewal, utilization related to Pre-Existing Conditions will be covered only upon payment of additional premium as determined by Pacific Cross. The following Disabilities, along with their complications and sequelae are Pre-Existing Conditions which may only be covered after a one (1) year waiting period even if the Insured Person was unaware of such Disability at the time of application for this Policy: 1. Mass/Tumors/Cyst of Internal Organs or on Skin, Muscular Tissue, Bone, or any form of Blood Dyscracias, regardless of histopathological feature; 2. Diabetes Mellitus, Hypertension, Cardiac and Vascular Conditions, and Cerebrovascular Diseases/Transient Ischemic Attack; 3. Urinary Calculi/Gallbladder Stone, including Cholecystitis; 4. Goiter and other Thyroid Disorders; 5. Asthma/ Chronic Obstructive Lung Disease: and 6. Degenerative Bone/Joint Disease including Gout, and Spinal Column Abnormalities.
- Medical Exclusions are medical conditions which are permanently excluded from my medical coverage. As such, entitlement to any benefit arising from such conditions will not be covered at any time under the Policy. I further acknowledge that I am aware that should there be any concerns on the representations that were made to me, I will immediately contact Pacific Cross through the fraud reporting link on the Pacific Cross website (www.pacificcross.com.ph).

I hereby authorize Pacific Cross Insurance, Inc. and/or Pacific Cross Health Care, 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 application form and any subsequent claim, and such other matters related thereto. A photocopy of this authorization is considered an original for all intents and purposes.

I understand that under Republic Act 9160 (Anti-Money Laundering Act) as amended by Republic Act 9194 and pertinent regulations, all insurance companies are required to satisfactorily establish the identities of all its customers. Hence, Pacific Cross Insurance, Inc. reserves the right not to accept and process any application for insurance if the customer fails to provide sufficient evidence to establish his identity.

During the effectivity of the Policy, the Policyholder agrees to the following:

- In case the Company is unable to comply with relevant customer due diligence (CDD) measures, as required under the Anti- Money Laundering Act, as amended and relevant issuances, due to the fault of the Policyholder, the Company may apply the following:
 - a. Measures to restrict the services available or prohibit any further transactions on the Policyholder until full and proper CDD measures have been successfully conducted; and
 - In case the foregoing is unsuccessful, terminate business relationship. The exercise of the Company of this measure shall only entitle the Policyholder to receive the unused portions of premium or withdrawal value, if any, whichever is applicable.
- 2. Be bound by obligations set out in relevant United Nations Security Council Resolutions relating to the prevention and suppression of proliferation financing of weapons of mass destruction, including the freezing and unfreezing actions as well as prohibitions from conducting transactions with designated persons and entities. I declare that I have read all particulars stated on all pages of this form and I hereby represent and confirm that the statements, answers and details indicated herein are true, complete and correct, were written by me

or by someone else upon my expressed instructions and shall be binding on me.

I understand that the receipt of payment by Pacific Cross does not constitute acceptance of my application or of my dependents until the corresponding application has been approved and the Policy has been issued to me or my dependents

I understand that the Policy and related Notices may be sent to me through e-mail, SMS or by mail based on the contact information I provided above.

DATA PRIVACY CONSENT: I understand that Pacific Cross collects and uses my personal information in order to service and administer the Insurance Policy and provide appropriate and timely Medical and Travel services. By signing this application form and all other forms attached to it, I agree that these information may be processed, shared, disclosed, transferred or used by Pacific Cross in accordance with the Data Privacy Act of 2012, its implementing rules and regulations, and the Pacific Cross Privacy Statement attached to this Application Form (a copy of the Pacific Cross Privacy Statement is also available at www.pacificcross.com.ph). 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 information.

POLICYHOLDERS' BILL OF RIGHTS: (1) Right to a financially sound and viable insurance Company; (2) Right to access insurance companies' official financial information; (3) Right to be informed of the license status of insurance companies, intermediaries and soliciting agents; (4) Right to be offered a duly approved insurance product; (5) Right to be informed of the benefits, exclusions and other provisions under the policy; (6) Right to receive the policy; (7) Right to confidentiality of information; (8) Right to efficient service from insurance companies, intermediaries and soliciting agents; (9) Right to prompt and fair settlement of claims; (10) Right to seek assistance from the Insurance Commission **NOTED BY:**

Signature over printed name of Principal Applicant:				Signature over printed name of Spouse:
"	e over printe Legal Age ent:	d		If the insured is a minor, signature over printed name of Applicant - payor (e.g., parent or guardian):
Date:				Place of signing:
	Month	Day	Year	

- I ensure that I, as the agent/AE/broker, have guided the Policyholder in completing all relevant and necessary information to assist the Company in assessing the application. I further declare that:

 1. The information provided by the Policyholder in the application form are accurate and complete;

 2. I/We also certify that I/We saw the Proposed Insured and have verified the information in this application against the original ID card/s presented and in doing so, have established the identity at the time of
- signing this application;
 3.I shall make known to the Company any and all factors which, if known to the Company, may result in an applicant receiving rated or no coverage at all; and

 4. Any additional information that shall be required by the Company in order to determine any particular application shall be provided on a timely basis.

Signature over printed name of Account Executive/Broker/Agent Date: If Broker/Agent, please Month indicate Broker/Agent code:

	PREMIUN	M COMPUTATION		
	Principal Applicant	Dependent 1	Dependent 2	Dependent 3
First Name				
CORE BENEFITS (Please check box a	nd write corresponding	premium based on age,	plan and option choses	1.)
lue Royale Plan A				
Plan B				
Plan C				
Others:		<u> </u>		<u> </u>
Subtotal Core Benefits Premium				
OPTIONAL BENEFITS (Please check	box and write additiona	al premium based on age	e, plan and option chose	en.)
ental - \$2,000 Annual Limit Plans A & B only; Dental already included Plan C)				
ision (\$700 Annual Limit, available only to roups of 21 members or more who all opt fo is benefit. Vision already included in Plan C	r			
ersonal Accident Coverage	<u> </u>	<u> </u>		
thers:				
Subtotal Optional Benefits Premiun	n			
DISCOUNT OPTIONS (Please check be	ox and calculate applica	ble discounts.) Note: Disco	unt options are only applied to	medical core benefits premi
= A - \$4.00 DST Amount				
Deductible Discount = C x % discou	<u>nt</u>			
Blue Royale				
\$1,000 deductible 15% discount (Plan A only)		U ———		
\$2,500 deductible				
30% discount (Plan A) 18% discount (Plan B)				
18% discount (Plan C)	<u> </u>	<u> </u>	<u> </u>	<u> </u>
\$5,000 deductible 40% discount (Plan A)				
24% discount (Plan B)		<u> </u>		Ē
24% discount (Plan C) Treatment Area Limitation Discoun			=	
contract provisions related to Treat		and that it was properly	explained to me by my	Agent).
BR (25% discount)				<u> </u>
thers:				_
Total Amount of Applicable Discount	t			
NNUAL PREMIUM = A + B - F (Core	Benefits Premium + Op	tional Benefits Premium	- Total Amount of App	licable Discounts)
nnual Premium (per person)				
			→ □₽ □\$	

IMPORTANT NOTE:

This application form is subject to medical evaluation. Premium loading for New Business, Take-Over applications and succeeding renewals may be applied subject to the results of the medical evaluation. Premiums are inclusive of all applicable taxes.

TERMS OF PAYMENT:	Annual	Semi-Annual (8% su	rcharge and DST charge will apply)
	(□₽□\$))
MODE OF PAYMENT:	Cash		
Į	Check (Please make check pa	yable to Pacific Cross Insurance, Inc.)	
Į	Bills Payment BDO	☐ Metrobank	
[Credit Card (Please fill out a C Representatives, or download		. You may request from our Medical Sales
	Web Payment - Pacific Cross's	s online payment gateway through www	pacificcross.com.ph accepts the following:
	Credit/Debit CardsGcashDragon Pay	MayaOver-the-counter (i.e., 7/11 OTC, Cliqq OTC, DA5 C	DTC and DragonPay OTC)
PHOTOS: Dependent	dents		
2 x 2 photo of Dependent	1	2 x 2 photo of Dependent 2	2 x 2 photo of Dependent 3





HEAD OFFICE

2nd Floor (Client & Partner Center), 8th Floor (Sales Center) and 18th Floor (Operations & Executive Center), 8 Rockwell Building, Hidalgo Drive, Makati City, Metro Manila, Philippines

Tel. No.: +63 2 8230-8511 Fax No.: +63 2 8230-8572

E-mail: info@pacificcross.com.ph

PROVINCIAL OFFICES

CEBU

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Tel. Nos.: +63 32 233-5812, +63 32 233-5816
E-mail: cebu@pacificcross.com.ph

CLARK

2nd Floor, The Medical City Clark, 100 Gatwick Gateway, Clark Global City, Clark Freeport Zone, Pampanga, 2023, Philippines
Mobile No.: +63 927 086-2452 E-mail: clark@pacificcross.com.ph

DAVAO

2nd Floor, Left Wing, Door No. 6, Matina Town Square, Mac Arthur Highway, Matina, Davao City, Philippines
Tel. No.: +63 82 297-7314 Telefax: +63 82 297-7151
E-mail: davao@pacificcross.com.ph

Pacific Cross remains **#HereForYou** in several provincial locations. For the complete details of our Agency Offices, please visit www.pacificcross.com.ph

You may request additional copies of this application form from our Medical Sales Representatives.

Application forms are also available on our website for download.