APPLICATION FOR AMENDMENT OF INSURANCE POLICY

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

Policy No.:		**Date of Last Renewal** (mm/dd/yyyy)**:**	
Principal Insured First Name:			
Principal Insured Middle Name:			
Principal Insured Last Name:			
Name of Policyholder/Principal Insured Person:			

TYPE OF CHANGE: (You may use a separate sheet if needed.)

☐ Upgrading of Plan/Benefit	**From:**		**To:**	
☐ Downgrading of Plan/Benefit	**From:**		**To:**	
☐ Inclusion of New Dependent/s *(Please fill out an application form.)*	**Name of New Dependent/s:**			
☐ Deletion of Dependent/s	**Name of Dependent/s:**		**Effective Date** (mm/dd/yyyy)**:**	
☐ Others *(Please specify.)*				

I hereby apply for the change in my Policy as specified above.
I understand that the change shall take effect only upon payment of the required premium, whenever applicable, and upon prior approval of such change by Pacific Cross at its Head Office.

MEDICAL QUESTIONNAIRE

DIRECTIONS: Please tick YES or NO to every question for each person to be amended.	**First Name of Applicant** ____		**First Name of Dependent 1** ____		**First Name of Dependent 2** ____		**First Name of Dependent 3** ____	
	YES	**NO**	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
1. Have you ever been declined, postponed, charged higher than standard premium rates, or offered modified or restricted benefits for life, critical illness, disability or health insurance?	☐	☐	☐	☐	☐	☐	☐	☐
2. Have you ever, been told that you have, had symptoms of, or been treated for cancer or lumps/growth of any kind, diabetes mellitus, raised blood pressure, chest pain, heart attack, stroke, cerebrovascular disease, any disease or disorder of the heart or blood vessels (e.g. coronary artery), the lungs, blood, kidney(s), liver, bowel or stomach, pancreas, hepatitis B or C (including Hepatitis B carrier), mental illness, rheumatoid arthritis, HIV or AIDS, alcoholism and/or drug addiction, neurological disorder (e.g. Multiple Sclerosis, Parkinson's disease, Motor Neurone Disease), physical impairments (e.g. loss of sight or hearing), or any other major illness?	☐	☐	☐	☐	☐	☐	☐	☐

3.	Have any of your natural parents or siblings had Dementia (including Alzheimer's disease), Cancer, Cardiomyopathy, Diabetes, Heart Disease, Stroke, Huntington's Disease, Parkinson's Disease, Polycystic Kidney Disease, Familial Adenomatous Polyposis, Motor Neurone Disease, Multiple Sclerosis or Muscular Dystrophy? If yes, please indicate family member, condition/illness, age at onset and age at death (if applicable).	☐ ☐	☐ ☐	☐ ☐	☐ ☐
4.	During the past 5 years, have you sought, currently seeking, or plan to seek, or do you plan to seek any treatment at any hospital, clinic, or doctor for any illness, injury, medical advice, operation or treatment and/or for any diagnostic test (such as an ECG, X-ray, blood test, etc.) not mentioned above, (exclude minor ailments like common colds, flu, minor accidental injuries which you have recovered from, routine health check-up with normal results) and/or are you taking medication on a regular ongoing basis?	☐ ☐	☐ ☐	☐ ☐	☐ ☐
5.	Do you currently have any signs or symptoms of illness or disease for which you have not sought medical advice?	☐ ☐	☐ ☐	☐ ☐	☐ ☐
6.	Since this Policy was initially approved or from its last reinstatement, has the Insured or Owner: a. Changed his/her occupation or country of residence? b. Is engaged in extreme sports/activities or hobbies (ex. mountaineering, sky diving, scuba diving, etc.)?	☐ ☐	☐ ☐	☐ ☐	☐ ☐
7.	Have you ever been, or are you currently a smoker/vaper? a. If no longer a smoker/vaper, provide no. of years since you last smoked/vaped.	☐ ☐ **_____ years**	☐ ☐ **_____ years**	☐ ☐ **_____ years**	☐ ☐ **_____ years**
8.	Height (ft. & in.):				
9.	Weight (lbs.):				

DETAILS OF YES RESPONSES

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 No.	Medical Condition	Nature/Date of Treatment	Current Status	Doctor's Name	Doctor's Current Info (Address, Phone No., Fax No.)
Name of Principal Applicant:					

Attachments: ☐ Medical test results ☐ Utilization/claims report ☐ Medical certificate ☐ Others:	**Remarks:**

Name of Dependent 1:					
Attachments:			**Remarks:**		
☐ Medical test results	☐ Utilization/claims report				
☐ Medical certificate	☐ Others:				
Name of Dependent 2:					
Attachments:			**Remarks:**		
☐ Medical test results	☐ Utilization/claims report				
☐ Medical certificate	☐ Others:				
Name of Dependent 3:					
Attachments:			**Remarks:**		
☐ Medical test results	☐ Utilization/claims report				
☐ Medical certificate	☐ Others:				

In upgrading my plan, I also understand that the following provisions shall apply:

1) Benefit Limit Upgrade: If the Eligible Benefits to any Insured Person under the terms of the Policy are increased while it is in force at the time of Policy Renewal, the following provisions shall apply:

a.) On the first 12 months of coverage from Policy Renewal:
- i. The Maximum Benefit Limit payable for the Disabilities that the Insured Person is afflicted with or had claimed prior to such Policy Renewal when benefits were increased shall not exceed the Maximum Benefit Limit previously available.
- ii. The inner limits of the new plan shall apply except for benefits with Lifetime Limits as stated in the Schedule of Benefit.
- iii. The Lifetime Limit payable for such benefit shall be the accumulated amount that the Insured Person had claimed any time prior to such Policy Renewal and shall not exceed the Lifetime Limit previously available.

b.) After the first 12 months of coverage from Policy Renewal:
- i. The Maximum Benefit Limit and inner limits payable for Disabilities incurred during and after the Policy renewal shall be the increased Maximum Benefit Limit and inner limits.
- ii. If the Maximum Benefit Limits of the old plan and new plan are both in per disability per lifetime, then any claim incurred and paid by the Company for such Disability prior to and during the first 12 months from such time of increase shall be deducted from the new Maximum Benefit Limit.
- iii. If the old Maximum Benefit Limit is per disability per lifetime and the new Maximum Benefit Limit is per combination of disabilities per year (aggregate), then any claim incurred and paid by the Company for such Disability prior to and during the first 12 months from such time of increase shall not be deducted from the new Maximum Benefit Limit. The Insured Person shall be entitled to the full amount of coverage based on the new Maximum Benefit Limit.

2) Deletion of the Treatment Area Limitation Upon Blue Royale Policy Renewal: If the Treatment Area Limitation discount option is deleted upon Policy Renewal, the following provisions shall be applicable:

a.) During the first 12 months of coverage from Policy Renewal, any In-Patient/Hospitalization Benefit as stated in Schedule 3 of the Policy including 90 days post-hospitalization follow-up care will not be covered if:
- i. The claim is related to a Disability that the Insured Person is afflicted with or had claimed any time prior to such Policy Renewal when the Treatment Area Limitation discount option was deleted; and
- ii. The medical availment is incurred in the following countries:
  Canada; United States of America, its dependent territories and the Caribbean Islands; Japan; People's Republic of China, Hong Kong and Singapore.

b.) After the first 12 months of coverage from Policy Renewal when the Treatment Area Limitation discount option is deleted, Disability that the Insured Person is afflicted with or had claimed any time prior this Policy Renewal may be covered even if incurred in the countries stated above unless a Treatment Area Limitation discount option is selected for the current Policy renewal.

Any previously excluded Disability shall remain to be excluded unless accepted by the Company for coverage with additional premium.

The Company may require a declaration of health or medical report at the time of application for increase of benefits, and, in its absolute discretion, may accept or decline such application for increase of benefits.

I declare that I have read all particulars stated on 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 failure to declare truthfully, or concealment, or misrepresentation of any significant condition in this declaration, including past and present medical conditions, consultations, treatments, hospitalizations, and insurance claims, whether filed or not, via no-cash-outlay or reimbursement, will result in the denial of any future claim, voiding of all the applicable insured's benefits under the plan and cancellation of the policy. I acknowledge that full disclosure is essential for a fair and accurate assessment of this application for amendment.

I agree that said change/s in my Policy shall not be considered in effect until all other requirements for such change are fully satisfied. I further agree that, prior to the approval of such change, any payment made or to be made shall only be considered as a deposit, which shall be refunded to me upon notice of cancellation, non-acceptance or disapproval.

I further agree that the change in my Policy is conditioned on the truthfulness of the above statements.

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 attached to this application form (also available at www.pacificcross.com.ph). By signing this application 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.

Signed at:		**Date** (mm/dd/yyyy)**:**	

Name of Insured:	

Signature of Insured:	

Name of Witness:	

Signature of Witness:	

If Insured is minor, name of parent or guardian:	

Signature of parent or guardian:	

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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.