APPLICATION FOR REINSTATEMENT OF INSURANCE POLICY

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

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

PLAN TYPE:

Payment Amount:		**Payment Date** (mm/dd/yyyy)**:**		**Official Receipt No.:**	

I hereby apply for reinstatement of my Policy by executing this declaration and payment of all amounts in arrears. I understand that the reinstatement shall take effect only upon payment of the required premium, including any loading, and upon prior approval of such reinstatement by Pacific Cross at its Head Office. Payment of the premium should be settled within 10 days after reinstatement approval date.

MEDICAL QUESTIONNAIRE

DIRECTIONS: Please tick YES or NO to every question for each person to be reinstated.	**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: ☐ Medical test results ☐ Utilization/claims report ☐ Medical certificate ☐ Others:			**Remarks:**		
Name of Dependent 2:					
Attachments: ☐ Medical test results ☐ Utilization/claims report ☐ Medical certificate ☐ Others:			**Remarks:**		
Name of Dependent 3:					
Attachments: ☐ Medical test results ☐ Utilization/claims report ☐ Medical certificate ☐ Others:			**Remarks:**		

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 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 reinstatement application.

I also understand that I cannot recover any claim amount for injury or illness that happened during the period that my Policy was lapsed. I further understand that benefits only become eligible for injuries that may occur after the reinstatement approval date, and for illnesses occurring wholly after 10 days from such reinstatement approval date.

I agree that my Policy shall not be considered reinstated until all other requirements for the reinstatement are fully satisfied and until this application is approved by Pacific Cross at its Head Office. I further agree that prior to the approval of my application, 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 approval of the reinstatement 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 (If Insured is Minor, signature of Parent/Guardian)**:**	

Name of Witness:	

Signature of Witness:	

Name of Policyholder:	

Signature of Client: (If Insured is other than Policyholder)**:**	

CONTACT US

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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.