

Application Reference No.: _____

☐ Select Standard ☐ Select Plus

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.

INSURANCE TYPE: ☐ Individual ☐ Family

PERSONAL INFORMATION: Principal Applicant

FIRST NAME: _____

MIDDLE NAME: _____ LAST NAME: _____

MOTHER'S MAIDEN NAME: _____

BIRTHDATE: _____ PLACE OF BIRTH: _____ NATIONALITY: _____
month day year

CIVIL STATUS: ☐ Single ☐ Married ☐ Widow/Widower ☐ Separated SEX: ☐ Male ☐ Female WEIGHT: _____ lbs. HEIGHT: _____ ft. in.

OCCUPATION: _____ NATURE OF WORK (Administration, Sales, etc.): _____

NAME OF EMPLOYER: _____ If 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.: _____

Are you and/or your immediate family member (within the second degree of consanguinity or affinity) entrusted with appointive or elective position in the Philippines or in a foreign state, a senior politician, judicial or military official, senior executive of government or state-owned or controlled corporations or political party official? ☐ No ☐ Yes (Name/Position/Public Office: _____)

Name	Birthdate (mm/dd/yyyy)	Relationship to Principal Applicant
BENEFICIARY: _____	_____	_____

PLACE OF BIRTH: _____ CONTACT NUMBER: _____ SEX: ☐ Male ☐ Female NATIONALITY: _____

ADDRESS: _____

GOV'T ISSUED CARD: ☐ Passport ☐ TIN ☐ SSS ☐ GSIS ☐ Driver's License ☐ Others (Pls. specify: _____) No.: _____

CONTACT INFORMATION

PERMANENT ADDRESS (Home Country)

(Number, Street, Block, Subdivision, City, Zip Code, Province, Country)

PRESENT ADDRESS (Country of Residence*):

RESIDENCE (Number, Street, Block, Subdivision, City, Zip Code, Province, Country)

BUSINESS (Number, Street, Block, Subdivision, City, Zip Code, Province, Country)

**Must be the Insured's place of residence or place of employment for not less than 6 months within the Period of Insurance. It is deemed to be the Philippines unless otherwise declared and covered by an Endorsement to the Policy.*

E-MAIL ADDRESS: _____

**This e-mail address will be used for sending your policy documents which may include sensitive medical information. Your membership card and all policy documents will be sent to you by e-mail.*

CONTACT DETAILS:

Residence Tel. No.: _____ Business Tel. No.: _____ Fax No.: _____

Mobile No.: _____ Alternate Mobile No.: _____ Alternate E-mail Address: _____

For Internal Use Only

SELLER'S DETAILS

Date Received: _____

☐ DIRECT (AE's ID No.: _____) ☐ INTERMEDIARY If Broker, name of Company: _____

If Agent, name of Agent: _____

Broker/Agent Code: _____

PRODUCT and PLAN DETAILS

Effectivity Date: (mm/dd/yyyy) _____

☐ New Applicant ☐ Additional Applicant ☐ Re-Application ☐ Take-Over Account ☐ Transferee

State insurance company/HMO (If a Take-Over Account): _____

REMARKS:

DEPENDENTS TO BE INSURED

Page 2 of 6 (Select Medical Plan Application Form)

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 applicable)		If self-employed, type of industry:																											
<table border="1"><thead><tr><th>Name</th><th>Date of Birth (mm/dd/yyyy)</th><th>Place of Birth</th><th>Relationship to Dependent 1</th><th>Contact Number</th></tr></thead><tbody><tr><td colspan="5">BENEFICIARY: </td></tr><tr><td colspan="5">ADDRESS: </td></tr><tr><td colspan="5">SEX: ☐ Male ☐ Female NATIONALITY: </td></tr><tr><td colspan="5">GOV'T ISSUED CARD: ☐ Passport ☐ TIN ☐ SSS ☐ GSIS ☐ Driver's License ☐ Others (Pls. specify:) No.: </td></tr></tbody></table>					Name	Date of Birth (mm/dd/yyyy)	Place of Birth	Relationship to Dependent 1	Contact Number	BENEFICIARY:					ADDRESS:					SEX: ☐ Male ☐ Female NATIONALITY:					GOV'T ISSUED CARD: ☐ Passport ☐ TIN ☐ SSS ☐ GSIS ☐ Driver's License ☐ Others (Pls. specify:) No.:				
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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: lbs.	HEIGHT: ft. in.																										
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OCCUPATION:		NATURE OF WORK (Administration, Sales, etc.):																											
NAME OF EMPLOYER: (if applicable)		If self-employed, type of industry:																											
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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: lbs.	HEIGHT: ft. in.																										
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OCCUPATION:		NATURE OF WORK (Administration, Sales, etc.):																											
NAME OF EMPLOYER: (if applicable)		If self-employed, type of industry:																											
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MEDICAL QUESTIONNAIRE *Page 3 of 6 (Select Medical Plan Application Form)*

[illegible]

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 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 the Company 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 the Company. 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 Dyscrasias, 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 the Company through client_services@pacificcross.com.ph

I hereby authorize the Company 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, the Company 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:
 - 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.
- 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 the Company 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 the Company 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 the Company in accordance with the Data Privacy Act of 2012, its implementing rules and regulations, and the the Company Privacy Statement attached to this Application Form (a copy of the Company 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 the Company 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:	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 Legal Age Dependent:	If the insured is a minor, signature over printed name of Applicant - payor (e.g., parent or guardian):		
Date: MonthDayYear	Place of signing:	Signature over printed name of Account Executive/Broker/Agent	
		Date: MonthDayYear	If Broker/Agent, please indicate Broker/Agent code:

PREMIUM COMPUTATION

	Principal Applicant	Dependent 1	Dependent 2	Dependent 3
First Name				
CORE BENEFITS (IN-PATIENT & EMERGENCY) (Please check box & write corresponding premium based on age, plan and option chosen.)				
Select Standard	☐	☐	☐	☐
Select Plus	☐	☐	☐	☐
Room & Board:				
Ward	☐	☐	☐	☐
Semi-Private	☐	☐	☐	☐
Private 2M	☐	☐	☐	☐
Private 3M	☐	☐	☐	☐
Private 5M	☐	☐	☐	☐
Core Benefits Premium				
SELECT OPTIONAL BENEFITS (Check box and write additional premium based on age, plan and option chosen.)				
Out-Patient Benefits:				
Standard	☐	☐	☐	☐
Executive	☐	☐	☐	☐
Additional Personal Accident Coverage:				
₱500,000 option	☐	☐	☐	☐
₱1,000,000 option	☐	☐	☐	☐
Dental:	☐	☐	☐	☐
Others:	☐	☐	☐	☐
Subtotal Optional Benefits Premium				
DISCOUNT OPTIONS (Check box and multiply chosen discounts accordingly.) Note: Discount options are only applied to medical core benefits premium.				
Core Benefits Premium Minus DST Amount				
Select 80/20 Co-Payment (25% discount, multiply by Core Benefits Premium minus DST Amount)	☐	☐	☐	☐
Group Discounts <i>(Multiply by the Subtotal Premium of: Core Benefits Premium - DST Amount + Select Optional Out-Patient Benefit Premium - Select Co-Payment Discount - Select Optional Dental Benefit Premium - Optional Additional PA, if any)</i>				
5% discount (7 - 15 members)	☐	☐	☐	☐
10% discount (16 or more members)	☐	☐	☐	☐
Others:	☐	☐	☐	☐
Total Amount of Applicable Discount				
ANNUAL PREMIUM = Core Benefits Premium + Select Optional Benefit Premium - Total Amount of Applicable Discount				
Annual Premium (per person)				
TOTAL ANNUAL PREMIUM				
GRAND TOTAL				₱

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% surcharge and DST charge will apply) (☐ ₱ _____)

MODE OF PAYMENT: ☐ Cash
☐ Check (Please make check payable to Pacific Cross Insurance, Inc.)
☐ Bills Payment ☐ BDO ☐ Metrobank
☐ Credit Card (Please fill out a Credit Card Payment Authorization form. You may request from our Medical Sales Representatives, or download a copy from our website.)
☐ Web Payment - Company's online payment gateway through www.pacificcross.com.ph accepts the following:

- Credit/Debit Cards
- Gcash
- Maya
- Over-the-counter (i.e., 7/11 OTC, Cliqq OTC, DA5 OTC and DragonPay OTC)

PHOTOS: Dependents

2 x 2 photo
of Dependent 1

2 x 2 photo
of Dependent 2

2 x 2 photo
of Dependent 3

CONTACT US

PARAMOUNT LIFE & GENERAL CORPORATION (INSURER OF RECORD)

15th Floor Sage House, 110 V.A. Rufino Street, Legaspi Village, Makati City 1229 Philippines
 Tel. No.: +63 2 8772-9200 Fax No.: +63 2 8772-9293 E-mail: insure@paramount.com.ph

HEAD SERVICING OFFICES

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 8325-0638 E-mail: info@pacificcross.com.ph

PROVINCIAL SERVICING OFFICES

CEBU

Unit 1 Mercedes Benz Tower, Mindanao Avenue, Cebu Business Park, Cebu City, Philippines
 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

Unit 905, 9th Floor, Aeon Towers, J.P. Laurel Ave., Bajada, Davao City, Davao Del Sur, 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

Paramount Life & General Insurance Corporation, using the Pacific Cross brand (herein referred to as the "Company"), is the Insurer of Record for Pacific Cross insurance policies.

**You may request additional copies of this application form from our Medical Sales Representatives.
 Application forms are also available on our website for download.**