SELECT MEDICAL PLAN
APPLICATION FORM

Pacific Cross Insurance, Inc.

PACIFIC CROSS

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 45 days from the date of your application.

2 x 2 photo of Principal Applicant

INSURANCE TYPE: ☐ **Individual** ☐ **Family**

PERSONAL INFORMATION: Principal Applicant

FIRST NAME:

MIDDLE NAME: LAST NAME:

MOTHER'S MAIDEN NAME:

BIRTHDATE: month day year PLACE OF BIRTH: NATIONALITY:

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: _____

☐ TIED AGENTS (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

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: _____ feet _____ inches

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 1	Contact Number
BENEFICIARY:					

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: _____ lbs. HEIGHT: _____ feet _____ inches

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: _____ lbs. HEIGHT: _____ feet _____ inches

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 3	Contact Number
BENEFICIARY:					

ADDRESS: _____ SEX: ☐ Male ☐ Female NATIONALITY: _____

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.	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. Are you currently covered under PhilHealth?	❑	❑	❑	❑	❑	❑	❑	❑
2. a. Are you currently covered by any medical policy? (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?	____ years		____ years		____ years		____ years	
b. If still a smoker, how many cigarette sticks per day?	____ cig. sticks		____ cig. sticks		____ cig. sticks		____ cig. sticks	
c. If no longer a smoker, provide no. of years since you last smoked.	____ years		____ years		____ years		____ years	
4. Do you engage in any form of sports? Please specify.	_____		_____		_____		_____	
If you tick YES to any of the questions, please provide DETAILS OF YES RESPONSES and attach the corresponding MEDICAL REPORTS indicated on page 4. Please ensure that you tell us about all your medical conditions and symptoms, whether past and/or present, known and/or suspected, whether or not professional advice was sought. If you were previously or already are a Pacific Cross Policyholder and you are applying to increase cover or you are applying as a new business under any Pacific Cross products, please include details of any condition for which you have filed claims since joining Pacific Cross.								
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?	❑	❑	❑	❑	❑	❑	❑	❑
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._____)?	❑	❑	❑	❑	❑	❑	❑	❑
l. (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?	❑	❑	❑	❑	❑	❑	❑	❑

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 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 upon payment of additional premium as determined by Pacific Cross.
- 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:

1. 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
   b. 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 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.

Signature over printed name of Principal Applicant:	Signature over printed name of Spouse:
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: *Month Day Year*	Place of signing:

NOTED BY:

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: *Month Day Year*	If Broker/Agent, please indicate agent's 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	☐	☐	☐	☐
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	☐	☐	☐	☐
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 *(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)*				
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.

PAYMENT OPTIONS

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 - Pacific Cross's online payment gateway through www.pacificcross.com.ph accepts the following:

- Credit/Debit Cards
- Gcash
- Maya
- Over-the-counter (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

HEAD OFFICE

2nd Floor (Client & Partner Center), 8th Floor and 18th Floors, 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

Unit 1 Mercedez 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.: +63 914 894-9211
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

We also have Agency Offices in:

Luzon: Cavite | Makati | Manila | Marikina | Muntinlupa | Naga | Novaliches | Pampanga
VisMin: Bacolod | Butuan | Cagayan de Oro | Davao | Dumaguete | General Santos

Visit www.pacificcross.com.ph for more information.

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