

# PrimaryCare International Medical Plan

## Medical Insurance Application

You are required to complete this form fully, accurately, and truthfully to the best of your knowledge and belief by providing all requested information in the relevant spaces and ticking the applicable boxes where indicated. All amounts are in US\$ unless otherwise specified.

### 1 Personal Details

#### Policyholder Details

First Name		Middle Name		Family Name	
Address					
Email			Phone (Incl. Country Code)		

#### Insured Person(s) Details

	Insured Person #1	Insured Person #2	Insured Person #3	Insured Person #4
First Name				
Middle Name				
Family Name				
Date of Birth (MM/DD/YY)	___/___/___	___/___/___	___/___/___	___/___/___
Sex	<input type="radio"/> Male / <input type="radio"/> Female	<input type="radio"/> Male / <input type="radio"/> Female	<input type="radio"/> Male / <input type="radio"/> Female	<input type="radio"/> Male / <input type="radio"/> Female
Relationship to Policyholder				
Occupation and Duties				
Passport or Government ID No.				
Country of Citizenship				
Country of Residence				

## 2 Plan Selection

Maximum Limit per Policy Year	Core \$2,000,000	Pulse \$2,500,000	Complete \$3,000,000
Insured Person #1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insured Person #2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insured Person #3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insured Person #4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 3 Choice of Annual Inpatient Deductible

Core Plan: Minimum annual inpatient deductible of US\$1,000 with choice of Annual Inpatient Deductible option of \$2,500 / \$5,000 / \$7,500 / \$10,000  
Pulse and Complete Plans: Choice of Annual Inpatient Deductible option of \$1,000 / \$2,500 / \$5,000 / \$7,500 / \$10,000

Deductible Amount	\$1,000	\$2,500	\$5,000	\$7,500	\$10,000
Insured Person #1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insured Person #2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insured Person #3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insured Person #4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 4 Optional Benefits

Optional for	Core	Core, Pulse, Complete	Core, Pulse, Complete	Core, Pulse, Complete	Pulse, Complete	Pulse, Complete	Pulse, Complete
Items	Outpatient (US\$3,000)	Semi-Private Room	High-Cost Country Co- Insurance	Worldwide Including USA	Dental Care	Optical Care	Maternity
Insured Person #1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> \$5,000 <input type="radio"/> \$10,000
Insured Person #2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> \$5,000 <input type="radio"/> \$10,000
Insured Person #3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> \$5,000 <input type="radio"/> \$10,000
Insured Person #4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> \$5,000 <input type="radio"/> \$10,000

**Semi-Private Room:** For treatments received in Hong Kong. This option is only available to Insured Persons whose Country of Residence is Hong Kong.

**High-Cost Country Co-Insurance:** This option is available exclusively to Insured Persons whose Area of Cover is Worldwide excludes treatment in the USA and whose Country of Residence is within the APAC region.

Please refer to the Benefit Schedule for full details of the respective options.

## 5 Payment Method

US Dollar (US\$) payment can be made by:	<ol style="list-style-type: none"> <li><b>CHEQUE</b> payable to PACIFIC CROSS INSURANCE COMPANY LIMITED</li> <li><b>WIRE / BANK TRANSFER</b> to the bank account as noted below, or</li> <li><b>CREDIT CARD</b> using the Payment Authorisation Form below, or Payment link for Visa / Mastercard upon request</li> </ol>
<b>Wire / Bank Transfer Information</b>	
Beneficiary Bank	Industrial and Commercial Bank of China (USA) NA 202 Canal Street New York NY 10013 USA ABA No: 026010948 SWIFT: ICBKUS3N
Beneficiary Account Name	Pacific Cross Insurance Company Limited
Beneficiary Account Number	62332

### Credit Card Authorisation Form

- Credit Card:       American Express (please complete details below)
- Visa or Mastercard (payment link will be provided)

Name of Cardholder:		Credit Card Account Number:	
Relationship to Policyholder:		Expiry Date (MM / YY):	____ / ____

Until further notice (one-month advanced written notice is required to terminate this payment instruction), I authorise PACIFIC CROSS INSURANCE COMPANY LIMITED to charge the premium, including instalment payments, for this insurance policy to my credit card account.

Signature of Cardholder: \_\_\_\_\_ Date (MM / DD / YY): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### Payment Option

<input type="radio"/> Annual or <input type="radio"/> Semi-Annual (52% of Annual) Premium Due:	
Preferred Effective Date (MM / DD / YY):	____ / ____ / ____

## 6 Medical Questions

Kindly provide information on your medical history. All information provided will be kept strictly confidential. Your complete and accurate responses will assist us to properly underwrite your policy. Each person to be included under the policy is required to complete the questions below. Parents or legal guardians are required to complete and sign on behalf of children.

	Insured Person #1	Insured Person #2	Insured Person #3	Insured Person #4
Height	_____ cm / ____ ft ____ in	_____ cm / ____ ft ____ in	_____ cm / ____ ft ____ in	_____ cm / ____ ft ____ in
Weight	_____ kg / _____ lbs	_____ kg / _____ lbs	_____ kg / _____ lbs	_____ kg / _____ lbs

Please select and tick the relevant response, all questions must be completed:

	Insured Person #1	Insured Person #2	Insured Person #3	Insured Person #4
<b>1. Have you used tobacco or nicotine products in the past 12 months?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>2. Ongoing or Recent Medical Care (Past 5 Years)</b> In the past 5 years, have you consulted a doctor or healthcare professional for any illness, injury or medical condition requiring follow-up, monitoring or repeated visits?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>3. Medication (Past 5 Years)</b> In the past 5 years, have you taken prescribed medication for more than one month continuously (excluding oral contraceptives)?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>4. Hospitalisation / Surgery (Past 5 Years)</b> In the past 5 years, have you been hospitalised, undergone surgery or medical procedures, or required treatment resulting in more than 10 days of care or more than one week off work?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>5. Abnormal or Pending Tests (Past 5 Years)</b> In the past 5 years, have you had any abnormal, inconclusive or pending medical test results, or been advised to undergo further investigations or monitoring?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>6. Current or Planned Treatment</b> Are you currently undergoing medical treatment, taking medication, awaiting test results, or scheduled for surgery or hospital admission?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>7. Major Medical Conditions</b> Have you ever been diagnosed with or treated for:				
i. Cancer tumour, cyst or abnormal growth	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
ii. Heart, vascular or circulatory disorder (including hypertension, high cholesterol, stroke or transient ischemic attack)	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
iii. Diabetes or thyroid/endocrine disorder	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
iv. Chronic respiratory disorder (including asthma or tuberculosis)	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
v. Liver, kidney, gastrointestinal or urinary disorder	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
vi. Neurological disorder (including epilepsy or multiple sclerosis)	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

## 6 Medical Questions – Continued

Please select and tick the relevant response, all questions must be completed:

	Insured Person #1	Insured Person #2	Insured Person #3	Insured Person #4
<b>7. Major Medical Conditions – Continued</b>				
Have you ever been diagnosed with or treated for:				
vii. Back, spine, joint or musculoskeletal disorder	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
viii. Blood disorder or abnormal blood condition	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
ix. Mental health or behavioural disorder	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
x. Chronic infectious disease, blood-borne virus or sexually transmitted infection (including HIV or Hepatitis B or C)	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
xi. Congenital or hereditary condition, implanted device or physical impairment	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
xii. Are you currently pregnant or have you ever suffered from any disease of the breast, abnormality of pregnancy or gynaecological disorders (for female only)	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>8. In the past 12 months, have you experienced any other medical conditions, signs, or symptoms, including, but not limited to, unexplained weight loss, persistent bleeding, lumps, chest pain, chronic cough, severe headaches, abdominal pain, or abnormalities of pregnancy, regardless of whether medical advice was sought, recommended, or received?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

## 6 Medical Questions – Continued

If you answered “Yes” to any of the Questions 1-8 in Medical Questions section above, please provide additional information and related medical report below, as applicable:

### Insured Person #1

Diagnosis			
Date of First Onset			
Treatment / Investigation Received			
Last Treatment Date			
Last Follow-Up Date			
Current Status			
Treating Doctor's Name			

### Insured Person #2

Diagnosis			
Date of First Onset			
Treatment / Investigation Received			
Last Treatment Date			
Last Follow-Up Date			
Current Status			
Treating Doctor's Name			

## 6 Medical Questions – Continued

If you answered “Yes” to any of the Questions 1-8 in Medical Questions section above, please provide additional information and related medical report below, as applicable:

### Insured Person #3

Diagnosis			
Date of First Onset			
Treatment / Investigation Received			
Last Treatment Date			
Last Follow-Up Date			
Current Status			
Treating Doctor's Name			

### Insured Person #4

Diagnosis			
Date of First Onset			
Treatment / Investigation Received			
Last Treatment Date			
Last Follow-Up Date			
Current Status			
Treating Doctor's Name			

## 7 Declaration

I hereby apply for a policy to be based on the above statements and declare that, to the best of my knowledge and belief, all answers to the foregoing questions are correctly and accurately recorded, and that they are full, complete and true.

I hereby authorise any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organisation, institution or person that has any records or knowledge of me or my health, to provide such information to PACIFIC CROSS INSURANCE COMPANY LIMITED. A photocopy of this authorisation shall be as valid as the original.

I further authorise the Company to provide my personal data, including but not limited to health information and details of the claims incurred, to reinsurance companies with whom the Company has or proposes to have dealings, or to any agent contractor or third-party service provider that provides services to the Company in connection with the operation of its business.

I hereby declare and agree that the Policyholder shall have the authority to deal with, receive or request for information from the Company concerning the Insured Person(s) in relation to any claims or matters arising from the policy issued pursuant to this application. I further agree that payment of any benefits hereunder to the Policyholder or Insured Person(s) in relation to all claims shall constitute a full discharge on the part of the Company in relation to such claims.

### Signature

Insured Person #1: \_\_\_\_\_ Date (MM / DD / YY): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Insured Person #2: \_\_\_\_\_ Date (MM / DD / YY): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Insured Person #3: \_\_\_\_\_ Date (MM / DD / YY): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Insured Person #4: \_\_\_\_\_ Date (MM / DD / YY): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Policyholder  
(If Different From  
the Insured Person) \_\_\_\_\_ Date (MM / DD / YY): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Broker Name:	
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