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

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

Insured Person(s) Details

If the Policyholder is an Insured Person: Please provide your details under Insured Person #1, and dependent details under Insured Person #2-5 (if any).

If the Policyholder is not an Insured Person: Please provide details starting from Insured Person #1-5.

	Policyholder / Insured Person #1	Insured Person #2	Insured Person #3	Insured Person #4	Insured Person #5
Family Name					
First Name					
Middle Name					
Date of Birth (MM/DD/YY)	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____
Sex	◯ Male / ◯ Female	◯ Male / ◯ Female	◯ Male / ◯ Female	◯ Male / ◯ Female	◯ Male / ◯ Female
Height	____ cm / __ ft __ in	____ cm / __ ft __ in	____ cm / __ ft __ in	____ cm / __ ft __ in	____ cm / __ ft __ in
Weight	_____ kg / _____ lbs	_____ kg / _____ lbs	_____ kg / _____ lbs	_____ kg / _____ lbs	_____ kg / _____ lbs
Relationship to Policyholder					
Occupation and Duties					
Passport or Government ID No.					
Country of Citizenship					
Country of Residence					

PrimaryCare is unavailable to applicants whose Country of Residence is **Canada, the United States of America, or any sanctioned country**.

2 Plan Selection

Maximum Limit per Policy Year	Core $2,000,000	Pulse $2,500,000	Complete $3,000,000
Policyholder / Insured Person #1	◯	◯	◯
Insured Person #2	◯	◯	◯
Insured Person #3	◯	◯	◯
Insured Person #4	◯	◯	◯
Insured Person #5	◯	◯	◯

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
Policyholder / Insured Person #1	◯	◯	◯	◯	◯
Insured Person #2	◯	◯	◯	◯	◯
Insured Person #3	◯	◯	◯	◯	◯
Insured Person #4	◯	◯	◯	◯	◯
Insured Person #5	◯	◯	◯	◯	◯

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
Policyholder / Insured Person #1	◯	◯	◯	◯	◯	◯	◯ $5,000 ◯ $10,000
Insured Person #2	◯	◯	◯	◯	◯	◯	◯ $5,000 ◯ $10,000
Insured Person #3	◯	◯	◯	◯	◯	◯	◯ $5,000 ◯ $10,000
Insured Person #4	◯	◯	◯	◯	◯	◯	◯ $5,000 ◯ $10,000
Insured Person #5	◯	◯	◯	◯	◯	◯	◯ $5,000 ◯ $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:	1. **CHEQUE** payable to PACIFIC CROSS INSURANCE COMPANY LIMITED 2. **WIRE / BANK TRANSFER** to the bank account as noted below, or 3. **CREDIT CARD** using the Payment Authorisation Form below, or Payment link for Visa / Mastercard upon request
Wire / Bank Transfer Information	
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

◯ Annual or ◯ 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.

Please select and tick the relevant response, all questions must be completed:	Policyholder / Insured Person #1	Insured Person #2	Insured Person #3	Insured Person #4	Insured Person #5
1. Have you used tobacco or nicotine products in the past 12 months?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
2. Ongoing or Recent Medical Care (Past 5 Years) 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?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
3. Medication (Past 5 Years) In the past 5 years, have you taken prescribed medication for more than one month continuously (excluding oral contraceptives)?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
4. Hospitalisation / Surgery (Past 5 Years) 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?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
5. Abnormal or Pending Tests (Past 5 Years) 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?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
6. Current or Planned Treatment Are you currently undergoing medical treatment, taking medication, awaiting test results, or scheduled for surgery or hospital admission?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
7. Major Medical Conditions Have you ever been diagnosed with or treated for:					
i. Cancer tumour, cyst or abnormal growth	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
ii. Heart, vascular or circulatory disorder (including hypertension, high cholesterol, stroke or transient ischemic attack)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
iii. Diabetes or thyroid/endocrine disorder	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
iv. Chronic respiratory disorder (including asthma or tuberculosis)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
v. Liver, kidney, gastrointestinal or urinary disorder	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
vi. Neurological disorder (including epilepsy or multiple sclerosis)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
vii. Back, spine, joint or musculoskeletal disorder	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
viii. Blood disorder or abnormal blood condition	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
ix. Mental health or behavioural disorder	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
x. Chronic infectious disease, blood-borne virus or sexually transmitted infection (including HIV or Hepatitis B or C)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
xi. Congenital or hereditary condition, implanted device or physical impairment	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ 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)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
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?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ 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:

Policyholder / 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			

Insured Person #3

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 #4

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

Insured Person #5

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

Additional Notes or Remarks (if any)

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):	_____ / _____ / _____
Insured Person #5:	_____	Date (MM / DD / YY):	_____ / _____ / _____
Policyholder (If Different From the Insured Person)	_____	Date (MM / DD / YY):	_____ / _____ / _____

Broker Name:	