COMPREHENSIVE INTERNATIONAL PLAN

PACIFIC CROSS

MEDICAL INSURANCE APPLICATION

Name of Policyholder (Family /First/Middle) _____

Address _____ Phone Home _____

_____ Office _____

_____ Mobile _____

E-mail _____ Fax _____

INSURED PERSON'S DETAILS	Insured Person #1	Insured Person #2	Insured Person #3	Insured Person #4
Family Name				
First & Middle Name				
Date of Birth (MM/DD/YY)	_____/_____/_____	_____/_____/_____	_____/_____/_____	_____/_____/_____
Sex	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Relationship to Policyholder				
Occupation and Duties				
Height	____ Cm /____ Ft ____ In	____ Cm /____ Ft ____ In	____ Cm /____ Ft ____ In	____ Cm /____ Ft ____ In
Weight	____ Kg / ____Lb	____ Kg / ____Lb	____ Kg / ____Lb	____ Kg / ____Lb
Passport or Government I.D. No.				
Country of Citizenship				
Country of Residence				
Community Rated Premiums	☐	☐	☐	☐
PLAN SELECTION				
Comprehensive (US$2,000,000)	☐	☐	☐	☐
Upgrade (US$3,000,000)	☐	☐	☐	☐
ADDITIONAL BENEFITS				
Rental Car Protection	☐	☐	☐	☐
Personal Accident Benefit P.A Sum Insured (in US$10,000's)	☐ _____	☐ _____	☐ _____	☐ _____
Beneficiary Designation				
Relationship to Insured Person				
DISCOUNT OPTIONS				
Treatment Area Limit (TAL)	☐	☐	☐	☐
20% Co-payment	☐	☐	☐	☐

PAYMENT METHOD

US Dollar (US$) payment can be made by:

1. CHECK payable to **PACIFIC CROSS INSURANCE COMPANY LIMITED**
2. TELEGRAPHIC TRANSFER to the bank account as noted below, or
3. CREDIT CARD using the Payment Authorization Form below.

Telegraphic 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 Payment Authorization Form

Credit Card: ☐ American Express

Name of Cardholder: _____ Credit Card Account No.: _____

Relationship to Policyholder: _____ Expiry Date (Month/Year): _____ / _____

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

Signature of Cardholder: _____ Date (MM/DD/YY): _____ /_____ /_____

PAYMENT OPTIONS

☐ **ANNUAL** or ☐ **SEMI-ANNUAL (52% of annual) PREMIUM DUE:** _____

Preferred Effective Date (MM/DD/YY): _____ / _____ / _____

• MEDICAL QUESTIONS •

Kindly provide information on your medical history. All information provided is kept in the strictest confidentiality. Your complete and accurate responses will assist us to properly underwrite your policy. Each person to be included in the policy is required to complete the below questions. (Parents are required to complete and sign on behalf of children).

	#1		#2		#3		#4	
	YES	NO	YES	NO	YES	NO	YES	NO
1. a) Are you currently covered by any medical insurance policy? (if "Yes", please provide us with a copy of the policy and benefits schedule)	☐	☐	☐	☐	☐	☐	☐	☐
b) Has any medical or life application been declined, rated or restricted? (if "Yes", please explain)	☐	☐	☐	☐	☐	☐	☐	☐
c) Has any medical or life policy been cancelled, withdrawn, rated or restricted (if "Yes", please explain)	☐	☐	☐	☐	☐	☐	☐	☐
2. At any time prior to the application, have you ever had symptoms of or been diagnosed, investigated or treated for any of the following: (underline the specific item and explain in the space provided below)								
a) speech defect, paralysis, hearing loss, physical defect, infirimity, congenital illness, genetic deformity or disease or chronic condition?	☐	☐	☐	☐	☐	☐	☐	☐
b) asthma, respiratory or allergic condition or disorder of the eyes, ears, nose or throat?	☐	☐	☐	☐	☐	☐	☐	☐
c) psychiatric or mental disorder, fainting, blackout, mood change, drug/alcohol addiction, seizure or fit?	☐	☐	☐	☐	☐	☐	☐	☐
d) hypertension, high/low blood pressure, chest pain, cholesterol problem, dizziness, heart or circulatory disorder?	☐	☐	☐	☐	☐	☐	☐	☐
e) kidney stone, venereal disease, or disorder of the bladder, prostate, kidney or genito-urinary tract?	☐	☐	☐	☐	☐	☐	☐	☐
f) hepatitis, ulcer, hemorrhoid, colitis or stomach, gall bladder, liver or bowel disorder?	☐	☐	☐	☐	☐	☐	☐	☐
g) sciatica, back pain, joint pain or rheumatic, arthritic, muscle, joint or bone disease or disorder?	☐	☐	☐	☐	☐	☐	☐	☐
h) blood abnormality or blood vessel disorder?	☐	☐	☐	☐	☐	☐	☐	☐
i) HIV, AIDS, AIDS Related Complex, or any indication of blood or immune system disorder?	☐	☐	☐	☐	☐	☐	☐	☐
j) cancer, tumor or cyst?	☐	☐	☐	☐	☐	☐	☐	☐
k) skin disorder?	☐	☐	☐	☐	☐	☐	☐	☐
l) diabetes mellitus, glandular or hormonal disorder?	☐	☐	☐	☐	☐	☐	☐	☐
m) rheumatic fever, gout, malaria or hernia of any kind?	☐	☐	☐	☐	☐	☐	☐	☐
n) gynecological disorder or disease or complication associated with pregnancy?	☐	☐	☐	☐	☐	☐	☐	☐
o) are you pregnant now? (for female only)	☐	☐	☐	☐	☐	☐	☐	☐
p) any other ailment, impairment, or injury?	☐	☐	☐	☐	☐	☐	☐	☐
3. Are you currently undergoing any investigations or taking any medications or receiving any form of treatment recommended or prescribed? (list with dosage)	☐	☐	☐	☐	☐	☐	☐	☐
4. Have you been a patient in a hospital or sanitarium for surgery, observation or treatment in the last 5 years?	☐	☐	☐	☐	☐	☐	☐	☐
5. Have you ever smoked or otherwise used tobacco? (if "Yes", please advise the consumption (pack) and duration of tobacco use)	☐	☐	☐	☐	☐	☐	☐	☐

- If you answered "Yes" to any of the above questions 1 to 5, please give complete details including medical history, diagnosis, nature/date of care and treatment received, date of last consultation and related medical reports, etc. (If the space provided is insufficient, please use a separate sheet for each Insured Person)

_____

_____

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- Kindly provide name and contact details of the personal physician or doctor for each Insured Person

_____

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_____

_____

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 authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my health, to give to **PACIFIC CROSS INSURANCE COMPANY LIMITED** any such information. A photostat copy of this authorization shall be as valid as the original.

I further authorize the Company to provide my personal data including but not limited to health 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 who 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: _____