

**• HEALTH INSURANCE APPLICATION •**

Name of Policyholder/Applicant Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  
 Address \_\_\_\_\_ Phone Home \_\_\_\_\_  
 \_\_\_\_\_ Office \_\_\_\_\_  
 \_\_\_\_\_ Mobile \_\_\_\_\_  
 E-mail \_\_\_\_\_ Fax \_\_\_\_\_

PERSONAL DETAILS	Insured Person #1	Insured Person #2	Insured Person #3	Insured Person #4
Last Name				
First & Middle Name				
Sex	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
Date of Birth (MM/DD/YY)	/ /	/ /	/ /	/ /
Relationship to Applicant				
Occupation and Duties				
Smoker	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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				

PERSONAL ACCIDENT (PA) BENEFICIARY INFORMATION
Name of Beneficiary
Relationship to Insured Person

PREMIUM CALCULATION	Insured Person #1	Insured Person #2	Insured Person #3	Insured Person #4
<b>MEDICAL PLANS - Check box or write in premium based on age, plan, option chosen and geographical loading.</b>				
Standard Medical Plan	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Private Room Option	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Comprehensive Medical Plan	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Geographical loading for residents in				
E.U. Countries / Switzerland - 15%	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Hong Kong - 20%	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
N. America - on request	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____

<b>DISCOUNTS - Check box or multiply chosen discounts by Medical Plan premium. Write in amount. Calculate Group Discount after deducting other Discounts from Medical Plan premium. Minimum premium US\$200 per Insured Person.</b>				
Standard Medical Plan	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
20% Co-payment - 25% discount	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Treatment Area Limit - 25% discount	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Outpatient Exclusion - 25% discount	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Comprehensive Medical Plan	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
20% Co-payment - 20% discount	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Treatment Area Limit - 20% discount	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
5-20 Person Group - 10% discount	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
21+ Person Group - 20% discount	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____

<b>ADDITIONAL BENEFIT PLANS - Check box or write in premium based on age, plan chosen and occupational class.</b>				
Dental	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Vision	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
PA - Sum Insured (in US\$10,000's)	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Premium	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Travel	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Optional Rental Car Protection	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____

<b>Annual Premium = Medical Plan premium - Discounts chosen - Group Discount + Additional Benefit Plans premium</b>				
<b>ANNUAL PREMIUM</b>				

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

**Policy Effective Date (MM/DD/YY):** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**• MEDICAL QUESTIONS •**

● Kindly tell us about yourself. All answers will be kept in strictest confidential. Your complete and correct responses will help us properly underwrite your goodself. Each person to be included in the policy is required to complete and return this form.

	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)	<input type="checkbox"/>	<input type="checkbox"/>
b) Has any medical or life application been declined, rated or restricted? (if "Yes", please explain)	<input type="checkbox"/>	<input type="checkbox"/>
c) Has any medical or life policy been cancelled, withdrawn, rated or restricted? (if "Yes", please explain)	<input type="checkbox"/>	<input type="checkbox"/>
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, infirmity, congenital illness or chronic condition?	<input type="checkbox"/>	<input type="checkbox"/>
b) asthma, respiratory or allergic condition or disorder of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>
c) psychiatric or mental disorder, fainting, blackout, mood change, drug/alcohol addiction, seizure or fit?	<input type="checkbox"/>	<input type="checkbox"/>
d) hypertension, high/low blood pressure, chest pain, cholesterol problem, dizziness, heart or circulatory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
e) kidney stone, venereal disease, or disorder of the bladder, prostate, kidney or genito-urinary tract?	<input type="checkbox"/>	<input type="checkbox"/>
f) ulcer, hemorrhoid, colitis or stomach, gall bladder, liver or bowel disorder?	<input type="checkbox"/>	<input type="checkbox"/>
g) sciatica, back pain, joint pain or rheumatic, arthritic, muscle, joint or bone disease or disorder?	<input type="checkbox"/>	<input type="checkbox"/>
h) blood abnormality or blood vessel disorder?	<input type="checkbox"/>	<input type="checkbox"/>
i) HIV, AIDS, AIDS Related Complex, or any indication of blood or immune system disorder?	<input type="checkbox"/>	<input type="checkbox"/>
j) cancer, tumor or cyst?	<input type="checkbox"/>	<input type="checkbox"/>
k) skin disorder?	<input type="checkbox"/>	<input type="checkbox"/>
l) diabetes mellitus, glandular or hormonal disorder?	<input type="checkbox"/>	<input type="checkbox"/>
m) rheumatic fever, gout, malaria or hernia of any kind?	<input type="checkbox"/>	<input type="checkbox"/>
n) gynecological disorder or disease or complication associated with pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
o) any other ailment, impairment, or injury?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently undergoing any investigations or taking any medications or receiving any form of treatment recommended or prescribed? (list with dosage)	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you been a patient in a hospital, clinic or sanitarium in the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>

● Kindly provide name and contact details of your personal physician or doctor.

\_\_\_\_\_

\_\_\_\_\_

● If you answered "Yes" to any of the above questions 1 to 4, 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.)

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\_\_\_\_\_

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

I/We 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/us or my/our 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.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

(MM/DD/YY)

Name of Applicant: \_\_\_\_\_ Broker: **ctibroker - 322**

(IN BLOCK LETTERS)