• SENIOR 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 ❑ Female ❑	Male ❑ Female ❑	Male ❑ Female ❑	Male ❑ Female ❑
Date of Birth (MM/DD/YY)	/ /	/ /	/ /	/ /
Relationship to Applicant				
Occupation and Duties				
Smoker	Yes ❑ No ❑	Yes ❑ No ❑	Yes ❑ No ❑	Yes ❑ No ❑
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
MEDICAL PLANS - Check box or write in premium based on age, plan, option chosen and geographical loading.				
Standard Medical Plan	❑ ________	❑ ________	❑ ________	❑ ________
Takeover Policy	❑ ________	❑ ________	❑ ________	❑ ________
Private Room Option	❑ ________	❑ ________	❑ ________	❑ ________
Comprehensive Medical Plan	❑ ________	❑ ________	❑ ________	❑ ________
Takeover Policy	❑ ________	❑ ________	❑ ________	❑ ________
Geographical loading for residents in				
E.U. Countries / Switzerland - 15%	❑ ________	❑ ________	❑ ________	❑ ________
Hong Kong - 20%	❑ ________	❑ ________	❑ ________	❑ ________
N. America - on request	❑ ________	❑ ________	❑ ________	❑ ________
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.				
Standard Medical Plan	❑ ________	❑ ________	❑ ________	❑ ________
20% Co-payment - 25% discount	❑ ________	❑ ________	❑ ________	❑ ________
Treatment Area Limit - 25% discount	❑ ________	❑ ________	❑ ________	❑ ________
Outpatient Exclusion - 25% discount	❑ ________	❑ ________	❑ ________	❑ ________
Comprehensive Medical Plan	❑ ________	❑ ________	❑ ________	❑ ________
20% Co-payment - 20% discount	❑ ________	❑ ________	❑ ________	❑ ________
Treatment Area Limit - 20% discount	❑ ________	❑ ________	❑ ________	❑ ________
5-20 Person Group - 10% discount	❑ ________	❑ ________	❑ ________	❑ ________
21+ Person Group - 20% discount	❑ ________	❑ ________	❑ ________	❑ ________
ADDITIONAL BENEFIT PLANS - Check box or write in premium based on age, plan chosen and occupational class.				
Dental	❑ ________	❑ ________	❑ ________	❑ ________
PA - Sum Insured (in US$10,000's)	❑ ________	❑ ________	❑ ________	❑ ________
Premium	❑ ________	❑ ________	❑ ________	❑ ________
Travel	❑ ________	❑ ________	❑ ________	❑ ________
Optional Rental Car Protection	❑ ________	❑ ________	❑ ________	❑ ________
Annual Premium = Medical Plan premium - Discounts chosen - Group Discount + Additional Benefit Plans premium				
ANNUAL PREMIUM				

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)	❑	❑
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, infirmity, congenital illness 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) 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) 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, clinic or sanitarium in the last 5 years?	❑	❑

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

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- 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:** ______________________
(IN BLOCK LETTERS)