

HEALTH INSURANCE PLAN



Injury & illness are never by choice
Your health insurance can be!



Illness nor injury never happens by choice. But quality health insurance is a serious choice for all of us. You always want the best medical care there without the worry of financial consequences.

Pacific Cross Insurance offers two specialized comprehensive medical insurance plans for people who want the best to cover the worst.



KEY FEATURES

- Free choice of doctors and hospitals
- Guaranteed renewability regardless of age, medical conditions or location
- Flexible geographic cover
- Free coverage for recreational sports
- Alternative medicines
- Direct payment to hospitals and 24-hour Worldwide Emergency Assistance
- Consideration of declared pre-existing conditions

*Don't Delay Your
Medical Insurance
While You have
A Choice!*

"PACIFIC CROSS" is a multi-line insurance underwriter with deep historical roots in a tradition of providing health insurance and health care services to the people of Asia and the world.

The Company was established in June, 1990 and incorporated in Samoa. It is part of regional group of specialist insurance business who has been operating in Asia for almost 40 years. Many of those companies are well recognized in their respective countries, such as Blue Cross Insurance, Inc. in the Philippines.

The group has unique competencies in the provision of medical and travel insurances which have been honed over decades of in these specialist markets. The depth of insurance experience of its directors, executives and dedicated experienced staff have contributed to the success of the company over the nineteen years of Pacific Cross' existence.

As the years have passed and success has smiled on "Pacific Cross", the Company has expanded to offer worldwide coverage for Medical Insurance, Life Insurance, Dental Insurance, Personal Accident Insurance, Travel Insurance and various tailor-made coverage of health and medical accident risk.

In an effort to best promote the well being of our clients, our commitment to personalized customer service is remarkable in the industry - we offer broad worldwide health insurance cover and guaranteed renewability. Our competitive advantages enable us to offer attractive rates while our reputation for quality service is widely known by our clients within the broker community. These are the reasons why people choose "Pacific Cross " for their insurance needs.

• HOSPITAL, OUTPATIENT & EMERGENCY MEDICAL PLAN •

| | STANDARD MEDICAL PLAN | COMPREHENSIVE MEDICAL PLAN |
|---|---|---------------------------------------|
| MAXIMUM BENEFIT FOR ANY ONE DISABILITY AND SEQUELAE | US\$1,000,000 | US\$2,000,000 |
| Covers normal, usual and customary charges for: | | |
| Room and Board | Semi-Private in E.U.Countries/HK/ N.America/Switzerland (Private Room option) or private in other countries | Private |
| Parent Accommodation An extra bed in the same room for a parent accompanying an insured child under 12 years old | 100% | 100% |
| Intensive Care Unit, Coronary Care Unit and Operating Room | 100% | 100% |
| Surgeon's Fee Includes pre-surgical assessment and normal post-surgical care | 100% | 100% |
| Organ Transplant Fees for kidney, heart, liver and bone marrow transplants (up to 50% for donor and the remaining percentages for recipient, at the option of the Insured Person) to a total of This benefit is a lump sum maximum per organ and no other policy benefits are payable in respect of Organ Transplant | US\$200,000 | US\$200,000 |
| AIDS Coverage will apply when signs or symptoms present for the first time after 5 years continuous coverage under the Policy and any renewal thereof, with lifetime limit of | US\$100,000 | US\$100,000 |
| Anaesthetist's Fee | 100% | 100% |
| Private Nurse Fee When certified necessary by the attending physician (at home for up to 30 days immediately after hospitalization) | 100% | 100% |
| Miscellaneous Inpatient Charges For required diagnostic laboratory fees, x-rays, prescribed medicines; professional fees; blood and plasma; wheel chair rentals; outpatient surgery; surgical appliances and devices; and intra-operative standard prosthetics (as approved by the Company) | 100% | 100% |
| Hospice Care For terminal illnesses with lifetime limit of | US\$10,000 | US\$10,000 |
| Maternity Benefit Maximum limit per pregnancy after a 12-month waiting period (90 days for miscarriage and therapeutic abortion) up to | US\$5,000 | US\$6,000 |
| Medical Check-up Annual limit for routine medical check-ups | Not Available | US\$500 |
| Psychiatric and Mental Disorders Hospital charges of US\$5,000 per year with lifetime limit of | US\$10,000 | US\$10,000 |
| Accidental Damage to Teeth Emergency treatment for up to 7 days following accidental loss or damage caused to sound natural teeth | 100% | 100% |
| Outpatient Benefit Physician and specialists' fees for office visits; physiotherapist, chiropractor and acupuncturist when referred by the attending physician; and, for required diagnostic laboratory fees, x-rays and prescribed medicines | 100% | 100% |
| Alternative Medicines (as part of "Outpatient Benefit ") Consultation fees for homeopath, bonesetter, herbalist and Chinese medicine practitioner; and prescribed herbs up to an annual limit of | US\$1,000 | US\$1,000 |
| Emergency Room Treatment and Emergency Local Ambulance Service | 100% | 100% |
| 24-Hour Emergency Assistance Services and Emergency Medical Evacuation Service Additional Travel Expenses (following Evacuation) One economy class airline ticket to return an Insured Person to the Country of Residence | Included | Included |

Note: "100%" herein means full reimbursement of the normal, usual and customary charges in accordance with the eligible room type or other localized circumstances or customs.

• ADDITIONAL BENEFIT PLANS WITH ADDITIONAL PREMIUM •

| Covers normal, usual and customary charges for eligible expenses: | STANDARD MEDICAL PLAN | COMPREHENSIVE MEDICAL PLAN |
|---|-------------------------------------|---|
| Dental Benefit 80% reimbursement up to an annual limit of | (US\$2,000 option) | US\$2,000 |
| Vision Benefit 80% reimbursement for eye examinations and prescription lenses annually for each Insured Person (this option is only available to groups of 21 or more people with 100% of the group participating) up to | (US\$500 option) | US\$500 |
| Personal Accident Benefit Covers loss of life, loss of one or both hands or feet, loss of vision in one or both eyes, or permanent and total disability caused directly and solely by an accident. (Maximum benefit is US\$100,000 after age 65 and coverage is terminated after age 75. Child benefit limits are US\$10,000 to US\$50,000) | (US\$100,000 to US\$500,000 option) | US\$100,000 for an adult / US\$10,000 for a child (with added load for Class 2 and 3) (US\$110,000 to US\$500,000 option) |
| Travel Benefit Covers the following eligible expenses worldwide when travelling outside your country of residence on trips lasting up to 90 days: | (option) | Included |
| Emergency Medical Expenses - covers illness or injury including "Emergency Evacuation" - (up to US\$25,000) with a maximum of US\$300 per day for hospital room and board which is doubled when the room fee includes medical service costs and tripled when the room fee also includes all professional services; and "Get You Home Benefit" - covers the additional cost of your own travel and accommodation necessarily incurred as a result of a covered disability to get you back home. | US\$35,000 | US\$35,000 |
| Baggage & Travel Documents - covers loss and damage of baggage and personal items including laptop computer; and loss of travel documents up to | US\$750 | US\$750 |
| Baggage Delay - covers purchase of essential clothing and toiletries if your checked baggage is delayed on arrival at your destination for over 12 hours up to | US\$125 | US\$125 |
| Personal Money - covers theft, burglary and robbery of cash, bank notes and travellers checks up to | US\$500 | US\$500 |
| Hospital Cash Income - pays US\$50 per day for each day you are hospitalized over 24 hours up to | US\$600 | US\$600 |
| Travel Delay - covers transportation expenses incurred as a direct consequence of travel delay resulting from serious weather conditions, industrial action, hijack, mechanical derangement if an Insured Person has to re-route his trip due to cancellation of a prior confirmed booking; or "Cash Allowance" - pays US\$25 for each full 12 hours delay up to a maximum of US\$100 | US\$650 | US\$650 |
| Cutailment of Trip & Cancellation Charges - covers irrecoverable prepaid travel arrangement deposits and any increased cost of travel in the event of death, serious injury or illness of the Insured Person, immediate family members or close business partner or travel companion of the Insured Person, witness summons, jury service, compulsory quarantine; natural disasters at the planned destination or complete destruction of the Insured Person's principal residence. | US\$2,500 | US\$2,500 |
| Optional Rental Car Protection - covers loss and damage occurs to a rental car result directly from fire, theft, collision or vandalism. Deductible: US\$250 | (US\$10,000 option) | (US\$10,000 option) |

• DISCOUNT OPTIONS •

| | STANDARD MEDICAL PLAN | COMPREHENSIVE MEDICAL PLAN |
|---|------------------------------|-----------------------------------|
| 20% Co-payment Option (you pay 20% and we pay 80% of eligible expenses) | 25% | 20% |
| Treatment Area Limit (excludes treatment in Hong Kong (SAR). Japan and North America where residents are eligible for this discount) | 25% | 20% |
| Outpatient Exclusion Option (Excludes outpatient coverage) | 25% | Not Available |

Note 1: Treatment Area Limit option is only available to residents in Indonesia, Korea, Malaysia, Philippines, Singapore, Taiwan, Thailand and Vietnam. Countries not listed will be given individual consideration.

2: After the Medical Plan premium is calculated, apply chosen discounts. Then, applications with 5 to 10 persons are eligible for a 10% group discount and 21 or more persons for a 20% group discount. The group discount is not applicable to Additional Benefit Plans.

• 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 |
|--|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| MEDICAL PLANS - Check box or write in premium based on age, plan, option chosen and geographical loading. | | | | |
| 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"/> _____ |

| | | | | |
|---|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| 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. | | | | |
| 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"/> _____ |

| | | | | |
|---|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| ADDITIONAL BENEFIT PLANS - Check box or write in premium based on age, plan chosen and occupational class. | | | | |
| 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"/> _____ |

| | | | | |
|---|--|--|--|--|
| 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) | <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.)

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)

• GENERAL INFORMATION •

Dental Benefits

A completed Oral Examination Report must be submitted with the first dental claim. All conditions requiring treatment as of the first dental visit are deemed to be pre-existing conditions.

Exclusions (Extract from the policy)

Medical plans do not cover care, treatment, services or supplies for:

- ☞ Pre-existing conditions not declared to and accepted by the Company;
- ☞ Which the Insured Person is entitled to indemnity from a third party or other benefit plan;
- ☞ Birth control; treatment of impotence or infertility (including artificial insemination, in-vitro fertilization, embryo transfer); sterilization reversal or elective abortion;
- ☞ Congenital conditions;
- ☞ Custodial Care, routine medical check-ups, or any treatments considered unnecessary by the Company, vaccinations, counseling, hearing tests, refractive defects of the eye, corrective eye surgery for refractive error, corrective devices, or dental treatment unless covered under the optional benefits cover of this policy for vision, dental, or medical check-up;
- ☞ Disability resulting from war or any act thereof, service in the military, naval or air force, riot, civil commotion;
- ☞ Hazardous or professional sports unless declared to and accepted by the Company;
- ☞ Intentionally self-inflicted injury, suicide, abuse of alcohol, drug addiction or venereal diseases;
- ☞ Cosmetic or reconstructive surgery;
- ☞ Prosthesis, orthotic devices, corrective devices and medical appliances not required for a surgical operation;
- ☞ AIDS, AIDS Related Complex, or Human Immunodeficiency Virus (HIV) and related illness which manifests. at any time within five years from the policy effective date; and
- ☞ Expenses incurred for provision of medical documentation required by the Company.

14-Day Free Look

You may return your policy within fourteen days after receipt for a full refund of the premiums paid.

FREE New Born Child Coverage

A child of an Insured Person is eligible for the same medical plan as the Insured Person 15 days after the later of the date of birth or the date of discharge on submission of application to the Company until the Insured Person's next renewal **for free**.

Geographical Loading

Applies to the Medical Plan (& Private Room Option) premium for residents to cover the high cost of medical care in that particular area.

Maternity Benefit

Expenses are covered where applicable after a 12-month waiting period. Miscarriage, therapeutic abortions, hydatiform mole and ectopic pregnancy are covered after 90 days. Benefit shall include all pre-natal and post-natal care, hospital room and board, professional fees, miscellaneous charges, and up to 7 days of nursery care.

No Claim Discount

A No Claim Discount will be offered to Insured Persons who are not entitled to Group Discount and whose policy remains claims-free at each renewal. The No Claim Discount will be applied as follows:

| | |
|--------|----------------------------|
| Year 0 | No discount |
| Year 1 | 10% discount |
| Year 2 | 15% discount |
| Year 3 | 20% discount (the maximum) |

If a claim is made by any Insured Person under the policy during a policy year, any No Claim Discount achieved will be lost and the status of the discount will be as at Year 0 shown above.

If a claim relating to the previous year is subsequently submitted and accepted, and a No Claim Discount has already been given, the Company reserves the right to deduct the equivalent monetary amount of the No Claim Discount from the value of the claim.

The No Claim Discount applies only to the premium in respect of the basic benefits. Claims against any Additional Benefit Plans will not affect the No Claim Discount.

Occupational Class

Personal Accident cover is based on the hazard class associated with an occupation and its duties. Class 1: very light hazards; Class 2: light hazards; Class 3: non-hazardous manual labor; and, Class 4: hazardous occupations. Class 3's are quoted on request and Class 4's have no cover.

Pre-existing Condition

Any Disability which existed before the policy effective date in respect of an Insured Person, which presented signs and symptoms of which the Insured Person was aware or should reasonably have been aware.

Premiums

Are based on the Insured Person's age on the first day of the policy year; the rate table in effect on the premium due date; and, residence, family status, payment mode and other factors which affect the cost of insurance. Premiums may be revised based on claims experience or other criteria which the Company, at its sole discretion, may determine. Policies renew automatically upon payment of renewal premium.

Treatment Area Limit

Does not apply to inpatient expenses incurred for emergency treatment of injury or acute illness which occurs wholly after the start of travel for up to 30 days of travel to the affected areas in any one policy year.

Waiting Period

Benefits are not paid for sickness during the first 30 days of coverage. Benefits for injuries due to covered accidents occurring wholly after the effective date are covered immediately.

This brochure is not a contract. For exact wording and complete details of the cover terms, conditions and exclusions of the policy, please refer to the policy itself.

If you have any questions relating to this application, please forward them to



CTI Brokers

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