



More than just insurance. Pacific Cross provides peace of mind.

PREMIER INTERNATIONAL PLAN

2024

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

INTRODUCTION & BENEFITS SCHEDULE

The Premier International Plan offers solid benefits at affordable prices. Choose from a range of additional benefits and discount options and customize the plan to meet your needs.

Schedule of Benefits (in US\$)

	PREMIER 250	PREMIER 500
Maximum Limit per Policy Year	US\$250,000	US\$500,000

Covers normal, usual and customary charges for:

Inpatient Benefits

Room and Board

Private in ASEAN countries (except Singapore), Semi-private elsewhere

Parent Accommodation

An extra bed in the same room for a parent accompanying an insured child under 12 years old

100%

Intensive Care Unit, Coronary Care Unit and Operating Room

100%

Surgeon's Fee

Includes pre-surgical assessment and normal post-surgical care

US\$30,000

100%

Anaesthetist's Fee

35% of eligible Surgeon's Fee

100%

Miscellaneous Inpatient Charges

For required diagnostic laboratory tests, x-rays, prescribed medicines; Professional Fees; blood and plasma; kidney dialysis; wheelchair rentals; outpatient surgery; surgical appliances and devices; and intra-operative standard prosthetics (as approved by the Company)

100%

Organ Transplant

Fees for kidney, heart, lung, 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 such as expenses for regular medical care or consultation, diagnostic tests and long-term medication are payable in respect of Organ Transplant

US\$37,500

US\$75,000

HIV / AIDS

Coverage will apply when HIV and/or its related illnesses present for the first time after 5 years continuous coverage under the Policy and any renewal thereof, with lifetime limit of

US\$25,000

US\$50,000

Hospital Cash Benefit

For inpatient treatment received without charge for up to 15 nights

US\$100 per night

Home Nursing

Immediately after a hospital confinement and certified to be medically necessary by the attending physician for up to 45 days

100%

Rehabilitation

When certified necessary by the attending physician for up to 45 days of inpatient, day case or outpatient treatment starting within 14 days immediately after the hospitalization

100%

Oncology

Radiotherapy, Chemotherapy, targeted therapy, immunotherapy and hormonal therapy (by way of infusion, injection or oral medications) received as inpatient, day case or outpatient treatments subject to a maximum limit of US\$5,000 for oral medications

100%

Hospice Care

For terminal illnesses with lifetime limit of

US\$25,000

Psychiatric and Mental Disorders

Hospital charges of US\$50,000 per year with lifetime limit of

US\$125,000

Maternity Benefit

Maximum limit per pregnancy after a 12-month waiting period (90 days for miscarriage and therapeutic abortion) up to When both parents are insured, the limit shall be increased by 50%

US\$2,500

US\$3,750

Free New Born Child Coverage

New born child 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.

Included

Emergency Benefits

Emergency Room Treatment

100%

Accidental Damage to Teeth

Emergency treatment for up to 7 days following accidental loss or damage caused to sound natural teeth

100%

Emergency Local Ambulance Service

100%

Emergency Assistance Services

Included

Repatriation of Mortal Remains

Covers costs for repatriation of mortal remains of the Insured Person to home country or country of residence

100%

INTRODUCTION & BENEFITS SCHEDULE

PREMIER 250

PREMIER 500

Outpatient Benefits

Physician and specialists' fees for office visits - Physiotherapist and chiropractor when referred by the attending physician; and for required diagnostic laboratory tests, x-rays and prescribed medicines

100%

Alternative Medicines

Fees for visits to homeopath, osteopath, podiatrist, acupuncturist, bonesetter, herbalist and Chinese medicine practitioner; and prescribed herbs up to an annual limit of

US\$250/year

US\$500/year

Medical Check-up and Vaccinations

Annual limit for routine medical check-ups and vaccinations

US\$350

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 Benefits

Covers normal, usual and customary charges for eligible expenses:

Dental Benefit

80% reimbursement up to an annual limit of

US\$2,000

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 80. Child benefit limit is 10% of the sum insured of his parent/guardian subject to the maximum of US\$50,000)

US\$100,000 to US\$500,000

Travel Benefit

Covers the following eligible expenses worldwide when travelling outside your country of residence on trips lasting up to 90 days:

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 if the hospital expense is on per diem basis, a daily reimbursement of all charges inclusive of room and board and professional services is limited to US\$1,000 if no detailed breakdown of charges is provided; and

"Medical Repatriation" - covers the additional cost of your own travel necessarily incurred as a result of a covered disability to get you back home following Emergency Evacuation.

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

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

Personal Money

Covers theft, burglary and robbery of cash, bank notes and travellers checks up to

US\$500

Hospital Cash Income

Pays US\$50 per day for each day you are hospitalized over 24 hours up to

US\$600

Travel Delay

Covers transportation expenses incurred as a direct consequence of travel delay resulting from serious weather conditions, natural disasters (earthquake, flood, hurricane, tornado, tsunami, etc.), 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 6 hours delay up to a maximum of US\$100

US\$650

Curtailment of Trip & Cancellation Charges

Covers irrecoverable prepaid travel arrangement deposits or 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

Optional Rental Car Protection

Covers loss and damage which occurs to a rental car result directly from fire, theft, collision or vandalism. Deductible: US\$500

US\$10,000

Discount Options

(Not applicable to Additional Benefits and subject to US\$200 minimum per Insured Person)

Treatment Area Limit (TAL)

When selected by the policyholder in respect of the policy provides coverage in Hong Kong (SAR), Japan, North America and Singapore provided the Insured Person has not been travelling to these locations for more than 30 accumulated days in one policy year. The coverage is for inpatient treatment in the event of an emergency resulting from an accident and/or the onset of an acute disability which the Insured Person had not suffered from or had been symptomatic prior to travelling.

25% Discount

Outpatient Exclusion (excludes outpatient coverage)

25% Discount

20% Co-payment (you pay 20% and we pay 80% of eligible expenses)

25% Discount

Group Discount

(Not applicable to Additional Benefits)

5+ persons

10% Discount

21+ persons

20% Discount

PREMIUM TABLES & KEY FEATURES

Premium for Premier 250 Plan (in US\$)

Age Band	0-3	4-18	19-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	76-80	81-85	86-90
Worldwide	2,000	1,666	2,432	2,617	2,829	3,025	3,225	3,580	4,051	4,803	6,266	8,914	12,515	16,685	23,616	32,588
TAL*	1,500	1,250	1,824	1,963	2,122	2,269	2,419	2,685	3,038	3,602	4,700	6,686	9,386	12,514	17,712	24,441

Premium for Premier 500 Plan (in US\$)

Age Band	0-3	4-18	19-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	76-80	81-85	86-90
Worldwide	2,075	1,729	2,897	3,115	3,363	3,597	3,778	4,230	4,836	5,728	7,476	10,633	14,930	19,908	28,176	38,881
TAL*	1,556	1,297	2,173	2,336	2,522	2,698	2,834	3,173	3,627	4,296	5,607	7,975	11,198	14,931	21,132	29,161

***TAL option** (Treatment Area Limit) is available to residents in Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Taiwan, Thailand, and Vietnam. TAL limits coverage in Hong Kong (SAR), Japan, North America and Singapore to Emergency Inpatient cover for accumulated 30 days per policy year (For full details please refer to Policy Wording).

Residents in the E.U Countries (except Germany), U.K. and Switzerland (15% loading to Worldwide Premium).
Residents in Singapore (30% loading to Worldwide Premium).
Residents in Hong Kong (30% loading to Worldwide Premium).
Geographical loading for North American residents is available on request.

****Medical Examination Requirement.** Applicants over the age of 65 must at their own expense have a Company approved physician submit a completed Physician Examination Report directly to the Company.

Medical Second Opinion

There are times when a second medical opinion is better than relying on one. A Medical Second Opinion is available for eligible medical conditions and accidents and will assess whether the original treatment is in line with state-of-the-art medicine and meets your needs. With this second opinion, you can see more clearly and take serious and far-reaching decisions on the basis of the best information.

Premium for Additional Benefits (in US\$)

Age Band	0-3	4-18	19-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	76-80	81-85	86-90
Dental	781	781	781	781	781	781	781	781	781	781	781	781	781	781	781	781
Travel	88	88	88	88	88	88	88	88	88	88	88	88	88	88	88	88
Rental Car Protection	Not available		83 (Age 23 to 75)										Not available			
Personal Accident	Class 1 Occupation -US\$1 per 1,000 Class 2 Occupation -US\$1.25 per 1,000														Not available	

No Claim Discount

A No Claim Discount will be offered to Insured Persons who are not entitled to Group Discount and have been insured for a period of not less than 12 months. While an Insured Person's plan remains claims-free at each renewal, the following No Claim Discount will be applied:

Year 0	Year 1	Year 2	Year 3	Year 4
No discount	10% discount	15% discount	20% discount	25% discount (the maximum)

If a claim is made by an Insured Person 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. The No Claim Discount applies only to the premium in respect of the basic benefits. Claims against any Additional Benefit Plans (Dental, Vision, Personal Accident and Travel Plans) and Medical Check-up and Vaccinations will not affect the No Claim Discount.

Key Features

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

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 Pacific Cross Insurance Company Limited at
E-mail: inquiry@pacificcross.com
Website: <http://www.pacificcross.com>

• 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

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 and genetic deformities or diseases;
- Weight treatment and management or bariatric surgery;
- Developmental abnormalities;
- Persistent Vegetative State or permanent neurological damage;
- Custodial Care, home care or services, routine medical check-ups, or any treatments considered unnecessary by the Company, vaccinations (except for the side effects resulting from receiving the COVID vaccinations), counselling, 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 except otherwise mentioned in the policy document;
- Prosthesis, orthotic devices, corrective devices and medical appliances not required for a surgical operation;
- AIDS, AIDS Related Complex, or Human Immunodeficiency Virus(HIV) and/or related illnesses which manifest at any time within five years from the Insured Person's 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.

Child Coverage

A child or children cannot be covered alone under an insurance policy. Parents or guardians must be included in order for a child/children to be insured.

Geographical Loading

Applies to the Medical Plan (& options) 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 (except pediatrician), miscellaneous charges, and up to 7 days of nursery care. When both parents are insured for the same medical plan, the maximum benefit shall be increased by 50%.

No Claim Discount

A No Claim Discount will be offered to Insured Persons who are not entitled to group discount and have been insuring for a period of not less than 12 months. While an Insured Person's plan remains claims-free at each renewal, the following No Claim Discount will be applied:-

Year 0	No discount
Year 1	10% discount
Year 2	15% discount
Year 3	20% discount
Year 4	25% discount (the maximum)

If a claim is made by an Insured Person 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 (Dental, Vision, Personal Accident and Travel Plans) and Medical Check-up and Vaccinations 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.

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	<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"/> Male <input type="checkbox"/> 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				

PLAN SELECTION				
Premier 250 (US\$250,000)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Premier 500 (US\$500,000)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADDITIONAL BENEFITS	<input type="checkbox"/> Dental	<input type="checkbox"/> Dental	<input type="checkbox"/> Dental	<input type="checkbox"/> Dental
	<input type="checkbox"/> Travel	<input type="checkbox"/> Travel	<input type="checkbox"/> Travel	<input type="checkbox"/> Travel
	<input type="checkbox"/> Rental Car Protection	<input type="checkbox"/> Rental Car Protection	<input type="checkbox"/> Rental Car Protection	<input type="checkbox"/> Rental Car Protection
Personal Accident Benefit P.A Sum Insured (in US\$10,000's)	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Beneficiary Designation				
Relationship to Insured Person				
DISCOUNT OPTIONS				
Treatment Area Limit (TAL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20% Co-payment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Exclusion Option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b) Has any medical or life application been declined, rated or restricted? (if "Yes", please explain)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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) <u>speech defect, paralysis, hearing loss, physical defect, infirmity, congenital illness, genetic deformity or disease or chronic condition?</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b) <u>asthma, respiratory or allergic condition or disorder of the eyes, ears, nose or throat?</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c) <u>psychiatric or mental disorder, fainting, blackout, mood change, drug/alcohol addiction, seizure or fit?</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d) <u>hypertension, high/low blood pressure, chest pain, cholesterol problem, dizziness, heart or circulatory disorder?</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
e) <u>kidney stone, venereal disease, or disorder of the bladder, prostate, kidney or genito-urinary tract?</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
f) <u>hepatitis, ulcer, hemorrhoid, colitis or stomach, gall bladder, liver or bowel disorder?</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
g) <u>sciatica, back pain, joint pain or rheumatic, arthritic, muscle, joint or bone disease or disorder?</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
h) <u>blood abnormality or blood vessel disorder?</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
i) <u>HIV, AIDS, AIDS Related Complex, or any indication of blood or immune system disorder?</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
j) <u>cancer, tumor or cyst?</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
k) <u>skin disorder?</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
l) <u>diabetes mellitus, glandular or hormonal disorder?</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
m) <u>rheumatic fever, gout, malaria or hernia of any kind?</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
n) <u>gynecological disorder or disease or complication associated with pregnancy?</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
o) <u>are you pregnant now? (for female only)</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
p) <u>any other ailment, impairment, or injury?</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Have you been a patient in a hospital or sanitarium for surgery, observation or treatment in the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Have you ever smoked or otherwise used tobacco? (if "Yes", please advise the consumption (pack) and duration of tobacco use)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

- 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)

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

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: _____