

A man and a woman are walking away from the camera on a sandy beach. The woman is wearing a bright yellow dress and the man is wearing a light blue shirt and khaki shorts. They are holding each other and looking out at the ocean. The background shows waves breaking on the shore under a clear sky.

Major

Medical
Plan

Injury & illness

are never by choice

Your health insurance

can be!

• MAJOR MEDICAL PLAN •

MAXIMUM BENEFIT FOR ANY ONE DISABILITY AND SEQUELAE

US\$250,000
(US\$1,000,000 option)

DEDUCTIBLE (per person per year)

US\$1,000
(US\$2,500 &
US\$5,000 option)

Covers normal, usual and customary charges for:

INPATIENT BENEFITS

Room and Board

Semi-Private up to
US\$350 per day
(Option to increase up to
US\$1,000 per day)
(Private in Indonesia, Malaysia,
Philippines & Thailand)

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 for each operation as per Surgical Schedule up to

US\$30,000
(US\$50,000 option)

Anaesthetist's Fee

35% of eligible Surgeon's Fee

Miscellaneous Inpatient Charges

For required diagnostic laboratory tests, 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%

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 are payable in respect of Organ Transplant

US\$100,000

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\$100,000

Hospital Cash Benefit

For inpatient treatment received without charge for up to 15 nights

US\$100 per night

Home Nursing

Immediately after hospitalization and certified to be medically necessary by the attending physician for up to 30 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 of hospitalization

100%

Oncology

Radiotherapy and chemotherapy (by way of infusion and injection) received as inpatient, day case or outpatient treatment

100%

Hospice Care

For terminal illnesses with lifetime limit of

US\$10,000

Psychiatric and Mental Disorders

Hospital charges with lifetime limit of

US\$5,000

Follow-up Care

For up to 90 days of normal care immediately after hospitalization. Outpatient physician and physiotherapist when certified medically necessary by the attending physician; and, for required diagnostic laboratory tests, x-rays and prescribed medicines

US\$2,500

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%
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

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 •

Covers normal, usual and customary charges for eligible expenses:

Dental Benefit 80% reimbursement up to an annual limit of	(US\$2,000 option)
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)
Travel Benefit Covers the following eligible expenses worldwide when travelling outside your country of residence on trips lasting up to 90 days:	(option)
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
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, 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
Curtailement 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 occurs to a rental car result directly from fire, theft, collision or vandalism. Deductible: US\$500	(US\$10,000 option)

• DISCOUNT OPTIONS •

(not applicable to Additional Benefit Plans and subject to US\$200 minimum per Insured Person)

US\$2,500 Deductible Option (you pay the first US\$2,500 of eligible expenses)	25% Discount
US\$5,000 Deductible Option (you pay the first US\$5,000 of eligible expenses)	35% Discount
Treatment Area Limit (excludes treatment in Hong Kong (SAR), Japan and North America where residents are ineligible for this discount)	25% Discount

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

2: Discounts for Deductible Options are not applicable to Optional Benefits.

3: After the Medical Plan premium is calculated, apply chosen discounts. Then, applications with 5 to 20 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.

• PREMIUMS (in US\$) •

AGE BANDS	0-3	4-18	19-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	For Renewal Only 61-65
MAJOR MEDICAL PLAN	708	708	886	978	1,069	1,164	1,265	1,358	1,581	1,693	1,828
Optional Benefits											
US\$1,000,000 Benefit	250	250	250	250	250	250	250	250	250	250	250
Additional Room & Board (per US\$50 increase)	32	32	32	32	32	32	32	42	42	42	53
US\$50,000 Surgeon's Fee	56	56	68	75	81	87	92	98	108	114	126
ADDITIONAL BENEFIT PLANS											
Dental Benefit	300	600	600	600	600	600	600	600	600	600	600
Personal Accident Benefit				Rate for Class 1 Occupation - \$1 per 1,000 Rate for Class 2 Occupation - \$1.25 per 1,000 Rate for Class 3 Occupation is available on request							
Travel Benefit	85	85	85	85	85	85	85	85	85	85	85
Rental Car Protection	Not available below age 23			75 for ages 23 to 75							

Note 1: 15% geographical loading applies to residents in E.U. Countries and Switzerland.

2: 20% geographical loading applies to residents in Hong Kong.

3: Geographical loading for North American residents is available on request.

4: US\$1,000,000 benefit option can be renewed up to age 75 and is subject to availability.

5: Medical premiums for age over 65 are available on request.

• PAYMENT METHOD •

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

- CHECK payable to **PACIFIC CROSS INSURANCE COMPANY LIMITED**
- TELEGRAPHIC TRANSFER to the bank account as noted below, or
- 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

Payment Mode: Annual ☐ Semi-Annual ☐

Credit Card: VISA/MasterCard ☐ American Express ☐

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

Relationship to Applicant: _____ 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 for this insurance policy to my credit card account.

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

Please send the completed application and payment to
Pacific Cross Insurance Company Limited
care of our third party administrator, International Administrators Limited
at the following address:
11/F, O.T.B. Building
160 Gloucester Road
Wanchai, Hong Kong, SAR
Fax: (852) 2573-2917
E-mail: inquiry@ialhk.com

• MAJOR MEDICAL 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 PLAN - Check box or write in premium based on age, option chosen and geographical loading.				
Major Medical Plan	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
US\$1,000,000 Benefit Option	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Additional Room & Board Option				
No. of units (US\$50/unit)	<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"/> _____
US\$50,000 Surgeon's Fee Option	<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.				
US\$2,500 Deductible - 25% discount	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
US\$5,000 Deductible - 35% 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"/> _____
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"/> _____
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. (Parents are required to complete and sign the form on behalf of children)

	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, genetic deformity or disease 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) hepatitis, 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 or sanitarium for surgery, observation or treatment 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 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.

Signature of Insured Person: _____ Date: _____ / _____ / _____
(MM/DD/YY)

Name of Insured Person: _____ Broker: _____
(IN BLOCK LETTERS)

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 a specialized medical insurance plan for people who want the best to cover the worst.

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

*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 is incorporated in Samoa. It is part of regional group of specialist insurance businesses which has been operating in Asia for over 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 experience 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 twenty years of the 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 and within the broker community. These are the reasons why people choose "Pacific Cross" for their insurance needs.

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 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, 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;
- ☛ 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 a female 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 (& options) premium for residents to cover the high cost of medical care in that particular area.

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 Pacific Cross Insurance Company Limited care of our third party administrator, International Administrators Limited in the manner set out below and at the address set out below:

Pacific Cross Insurance Company Limited
c/o International Administrators Limited
11/F, O.T.B. Building
160 Gloucester Road
Wanchai, Hong Kong, SAR
Tel: (852) 2573-2278, (852) 2573-2535
Fax: (852) 2573-2917
E-mail: inquiry@ialhk.com
Website: <http://www.pacificcross-insurance.com>