BLUE CROSS INSURANCE, INC

Blue Royale DuoProtect

BLUE ROYALE DUO PROTECT APPLICATION FORM

Directions: Please answer this application form as truthfully as possible. All sections must be completed using a ballpen or signpen. Please use block letters. Application forms without the appropriate signatures and dates will be returned. This form is valid for one (1) month from the date of your application.

PERSONAL INFORMATION: Applicant

FIRST NAME:

MIDDLE NAME: LAST NAME:

MOTHER'S MAIDEN NAME:

If part of a Group Account, Company/Organization Name:

BIRTHDATE: month day year SEX: ☐ Male ☐ Female WEIGHT: lbs. HEIGHT: feet inches

NATIONALITY: CIVIL STATUS: ☐ Single ☐ Married ☐ Widow/Widower ☐ Separated

OCCUPATION: NATURE OF WORK (Administration, Sales, etc.):

NAME OF EMPLOYER: If self-employed, nature of business:

Tax Identification No. (TIN) **(required)**:

Please provide any of the following identification numbers: Social Security System No.:

Gov't Service & Insurance System No.: Passport No.:

ITINERARY:

	Name	Date of Birth	Current Age	Relationship to Principal Applicant
BENEFICIARY:				

CONTACT INFORMATION

PRESENT ADDRESS: RESIDENCE (Number, Street, Block, Subdivision, City, Zip Code, Province, Country)

BUSINESS (Number, Street, Block, Subdivision, City, Zip Code, Province, Country)

MAILING ADDRESS:
☐ Residence
☐ Business

PERMANENT ADDRESS: (Number, Street, Block, Subdivision, City, Zip Code, Province, Country)

CONTACT DETAILS: Residence Tel. No.: Business Tel. No.: Fax No.:

Mobile No.: E-mail Address:

Please proceed to next page. ☛

LIST OF DEPENDENTS

IF MARRIED:	**Name**	**Date of Birth**	**Current Age**
Spouse			
Children			

IF SINGLE:	**Name**	**Date of Birth**	**Current Age**
Mother			
Father			
Siblings			

MEDICAL QUESTIONNAIRE

DIRECTIONS: Please tick yes or no to every question for each person to be insured. If you tick yes to any of the questions in this **MEDICAL QUESTIONNAIRE**, please provide **DETAILS OF YES RESPONSES** found on the next page. Please ensure that you tell us about all your medical conditions and symptoms, whether past and/or present, known and/or suspected, whether or not professional advice was sought. If you were previously or already are a Blue Cross customer and you are applying to increase cover or you are applying as a new business under any Blue Cross product, please include details of any condition for which you have filed claims since joining Blue Cross.

	YES	NO
1. Are you currently covered under the Medicare Act (PhilHealth) of the Philippines?	☐	☐
2. a. Are you currently covered by any medical policy? (Please include a copy of the policy and benefit schedule.)	☐	☐
b. Has any of your medical or life application been declined, rated or restricted?	☐	☐
c. Has any of your medical or life policy been cancelled, withdrawn, rated or restricted?	☐	☐
3. At any given time, have you had symptoms of or been diagnosed or treated for any : **a.** speech defect, paralysis, hearing loss, physical defect, infirmity, congenital illness or chronic condition?	☐	☐
b. respiratory or allergic condition or disorder of the eyes, ears, nose or throat?	☐	☐
c. nervous or mental disorder, sleep disorder/insomnia, fainting, blackout, mood change, drug/alcohol addiction, seizure or fit?	☐	☐
d. blood pressure problem, chest pain, cholesterol problem, dizziness, anemia, heart or circulatory disorder?	☐	☐
e. gall/kidney stone, venereal disease, or disorder of the bladder, prostate, kidney or genito-urinary tract?	☐	☐
f. ulcer, hemorrhoid, colitis or stomach, liver or bowel disorders?	☐	☐
g. sciatica, back pain, joint pain or rheumatic, arthritic, joint or bone disease?	☐	☐
h. AIDS/AIDS Related Complex, or any indication of blood or immune system connective tissue disorder?	☐	☐
i. mass, lump, cyst, tumor or cancer?	☐	☐
j. skin disorder?	☐	☐
k. hormone or glandular disorder or condition such as:		
k1. diabetes	☐	☐
k2. thyroid (ex: goiter)/parathyroid disorder	☐	☐
k3. obesity	☐	☐
k4. endocrine tumors	☐	☐
k5. others (Please specify._____)	☐	☐
l. gynecological/menopausal disorder or pregnancy-related disease or complication?	☐	☐
4. Have you ever been prescribed or recommended, or are currently taking any medication or treatment? (Please list dosage and other details on next page.)	☐	☐
5. Have you been a patient in a hospital, clinic or sanitarium at any given time?	☐	☐
6. Have you been advised to have any medical test or procedure other than as noted above? (Please provide details on next page.)	☐	☐
7. Have you ever been, or are you currently a smoker?	☐	☐
a. If yes, for how long?	____ years	
b. If still a smoker, how many cigarette sticks per day?	____ cig. sticks	
8. Do you engage in any form of sports? (Please specify on next page.)	☐	☐
9. Is there any accident, injury, illness, disease, condition or additional information not covered in the above? (Please provide details of any other medical condition or history that a reasonable person may consider would have a bearing on the acceptance of this application.)	☐	☐
10. Are there additional pages forming part of your declarations that are attached to this Application Form?	☐	☐

Please proceed to next page.

DETAILS OF YES RESPONSES

Qstn No.	Medical Condition	Nature/Date of Treatment	Current Status	Doctor's Name	Doctor's Current Info (Address, Phone No., Fax No.)

If Yes to Qstn No. 10, please specify attachments:

❑ Medical test results ❑ Medical certificate

❑ Utilization/claims report ❑ Others _____

Remarks (for Blue Cross use only):

I understand that failure to answer truthfully the questions in this application, or concealment, or misrepresentation of any significant condition will result in the voiding of all the applicable insured's benefits under the plan. I also understand that this application may be returned to me if I fail to complete all details requested.

I understand that this application form and all test results are subject to medical evaluation. I understand that a premium loading may be applied subject to the results of the medical evaluation.

I hereby authorize Blue Cross Insurance, Inc. and/or Blue Cross Health Care, Inc. and all persons duly authorized and acting on their behalf to request and receive any information or document and record from any hospital, clinic, laboratory, attending physician and other health service provider, which information or document relates to any medical history, examination, laboratory test results and/or treatment in connection with this application form and any subsequent claim, and such other matters related thereto. A photocopy of this authorization is considered an original for all intents and purposes.

I declare that I have read all the particulars stated on all pages of this application form, and confirm that the answers and details written are complete and true, whether written by me or by someone else on my behalf, and shall be binding on me.

Signature over printed name of Principal Applicant:	Signature over printed name of Spouse:
Signature over printed name of Legal Age Dependent:	If the insured is a minor, signature over printed name of Applicant - payor (e.g. parent or guardian):
Date: *Month Day Year*	

NOTED BY:

I certify that I have validated the information in this application against the original I.D. card/s presented and in doing so, have established the applicant's identity.	
Signature over printed name of Account Executive/Broker/Agent	
Date: *Month Day Year*	If Broker/Agent, please indicate agent's code:

PREMIUM COMPUTATION

Core Benefits	+	Optional Benefits	-	Deductible & Discount Options	=	Annual Premium

IMPORTANT NOTE: This application form is subject to medical evaluation. Premium loading may be applied subject to the results of the medical evaluation. Premiums are inclusive of all applicable taxes.

Please proceed to next page.

PAYMENT OPTIONS

TERMS OF PAYMENT: ☐ Annual (☐₱ ☐$ _____)

☐ Semi-Annual (with 8% surcharge) (Annual Premium x 0.54 = ☐₱ ☐ $_____)

MODE OF PAYMENT:

☐ Cash

☐ Check (Payable to Blue Cross Insurance, Inc.)

☐ Bills Payment: ☐ BPI ☐ Banco de Oro ☐ Metrobank

☐ Credit Card

CREDIT CARD PAYMENT AUTHORIZATION:

☐ **Straight Payment**

BANK: ☐ VISA ☐ AMEXCO ☐ MASTERCARD ☐ SECURITY DINERS INT'L

☐ **Deferred Payment (Available for locally issued credit cards and Peso premiums with a minimum payment of PhP3,000.00)**

BANK: ☐ **RCBC** (☐ *RCBC* ☐ *JCB* ☐ *myDream JCB)*

☐ **BDO** (☐ *BDO* ☐ *JCB* ☐ *AMEX)*

☐ **MBTC** (☐ *MetroBank* ☐ *PSBank* ☐ *Cebu Pacific MasterCard* ☐ *Toyota MasterCard)*

TERMS: ☐ **Regular Installment**: (☐ *3 months* ☐ *6 months* ☐ *9 months* ☐ *12 months)*

☐ **Zero Percentage Interest "0%"**: (☐ *3 months* ☐ *6 months)*

Name of Cardholder:

Relationship to Applicant *(If Cardholder is other than the Applicant)*:

Credit Card Account No.:

Batch Code *(Last 3 numbers indicated at the back of credit card. For AMEXCO, 4 numbers in front of the credit card):*

Card Expiry Date *(day/month/year)*: Issuing Bank:

Billing Address: Contact Details:

Terms of Premium Payment: ☐ Annual (☐₱ ☐$ _____)

☐ Semi-Annual (☐₱ ☐$ _____)

I authorize ☐ Blue Cross Insurance, Inc. ☐ Blue Cross Health Care, Inc.

to charge the amount of ☐₱ ☐$ to my credit card account.

Cardholder's Signature over Printed Name:	Date: *Month Day Year*	Approval Code:

NOTES:
- A photocopy of at least one (1) valid ID with signature and a photocopy of credit card (front only) are required.
- Please expect a confirmation call from a Blue Cross representative in case of non-submission of the above requirements.

Confirmed by (Name & Signature of Blue Cross Representative):	Date: *Month Day Year*

CONTACT US

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You may request additional copies of this application form from our Medical Sales Representatives.