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Hospital Cash Card

Underwritten by

PACIFIC CROSS PHILIPPINES

WHO IS PACIFIC CROSS?

Non-Life Insurance Market Specialist

Ranked Top 4 out of 55 Non-Life Insurance companies according to Premiums Earned and Top 6 in Net Premium Written in 2022

Corporate Performance

Wrote over **PHP2.2 Billion** of Net Premium,
Reached **PHP4.8 Billion** in Assets,
PHP2.8 Billion in Net Worth

Extensive Business Channels

Direct Account Executives, Exclusive Agencies, Incubator Channel, Independent Advisors & Agencies, Licensed Brokers Nationwide

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PACIFIC CROSS PHILIPPINES

VISION

To be our client's recommended medical & travel insurance provider.

MISSION

To help our clients protect their health and financial well-being by providing value-for-money medical and travel insurance products.

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SISTER COMPANIES

Hong Kong	International Administrators, Ltd.
Thailand	Pacific Cross Health Insurance PCL
Vietnam	Pacific Cross Vietnam
Indonesia	International Services Pacific Cross

SELECT PREPAID PLANS

- Budget-friendly medical insurance
- Allows selection of plans to purchase

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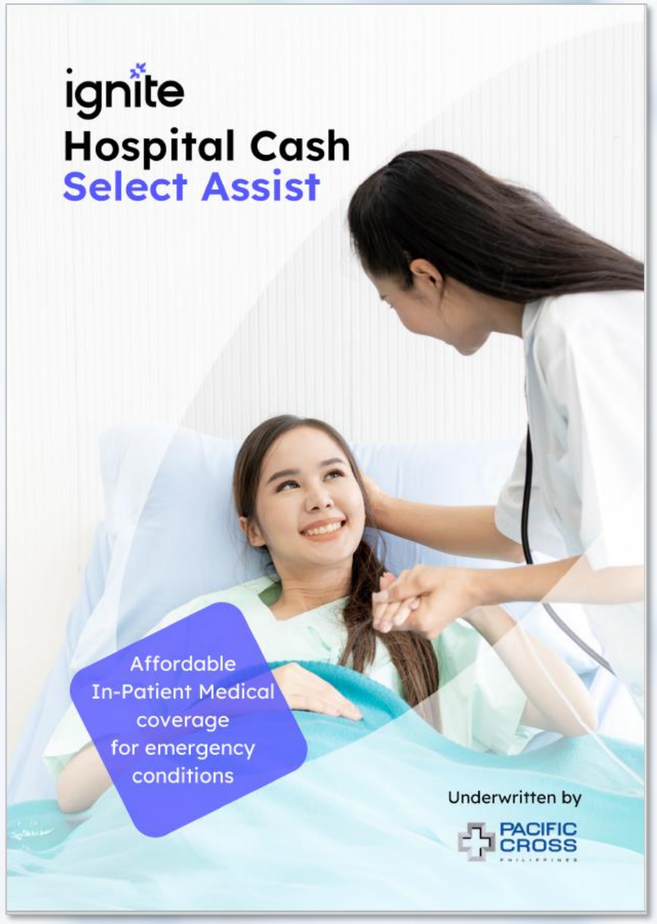
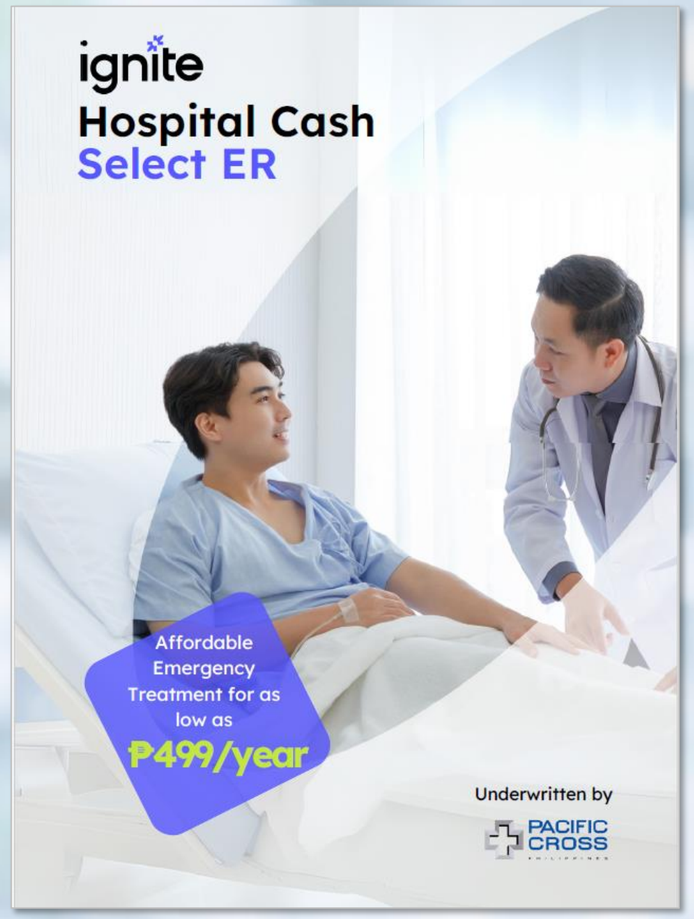
SELECT PREPAID | PLANS





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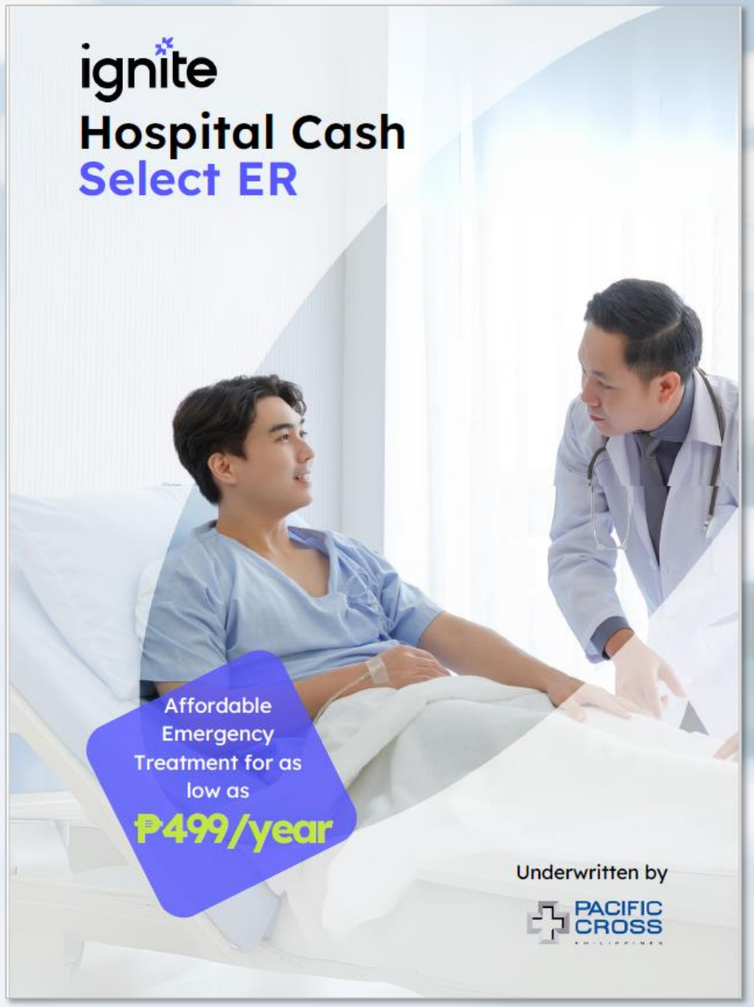
SELECT PREPAID | SELECT ER

Select ER Medical Insurance			
Plan Option	**PLAN A**	**PLAN B**	**PLAN C**
MBL	PHP5,000	PHP10,000	PHP20,000
Premium	PHP499	PHP849	PHP1,199

Coverage for single occurrence of an emergency medical condition within period of insurance availed through:

- Reimbursement or Direct Settlement of actual medical cost incurred in Emergency Room
- Lump Sum cash assistance for the Emergency In-patient Treatment regardless of the incurred medical cost

Issue age: 15 days to 65 years old
Waiting Period: 7 days after successful registration



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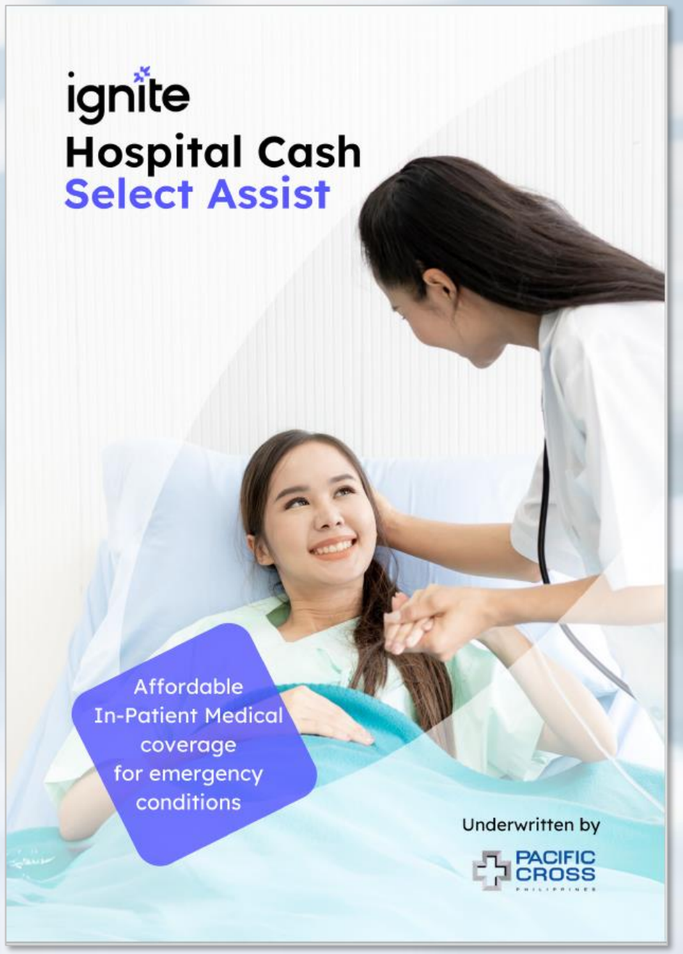
SELECT PREPAID | SELECT ASSIST

Select Assist Medical Insurance			
Plan Option	**PLAN A**	**PLAN B**	**PLAN C**
MBL	PHP10,000	PHP20,000	PHP30,000
Premium	PHP1,499	PHP2,699	PHP3,899

Coverage for the in-patient medical treatment cost for an eligible emergency condition

Issue Age: 15 days to 65 years old
Waiting Period: 7 days after successful registration



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SELECT PREPAID | SELECT MEDSECURE

Select MedSecure Medical Insurance			
Plan Option	**PLAN A**	**PLAN B**	**PLAN C**
MBL	PHP2,000	PHP2,500	PHP5,000
Premium	PHP549	PHP649	PHP950

One time reimbursement of actual amount of:
- Prescribed take-home medications
- Vitamins
- Supplements

For necessary follow-up care during 90 days immediately after a single period of confinement/hospitalization

Issue Age: 15 days to 60 years old
Waiting Period: 15 days after successful registration

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SELECT PREPAID | PROVISIONS

Once a claim is approved, the policy is **considered as terminated**.
Coverage will remain active if a claim is denied.

Official Receipts & acceptable proof of payment must be **collated for one-time submission.**

Only 1 plan option can be purchased during period of insurance, however, all 5 prepaid plans can be purchased at the same time.

The **Waiting Period** specified for each plan must pass before any claim is submitted.

For Select ER & Select Assist:
Client can purchase a new prepaid plan 60 days after their policy was terminated due to an approved claim.

Person to be insured must be within the **Issue Age** specified in the plan upon purchase and registration.

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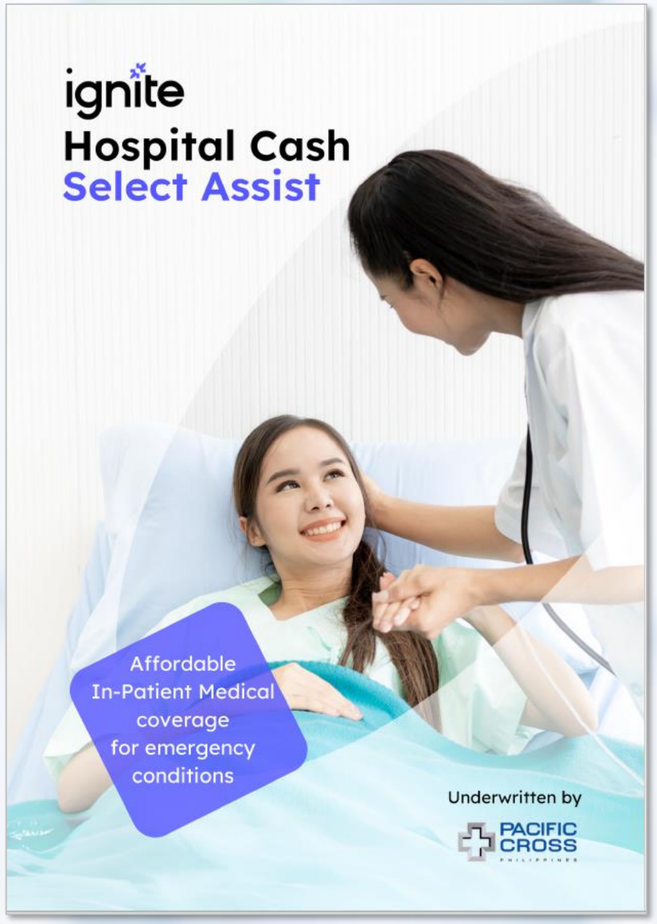
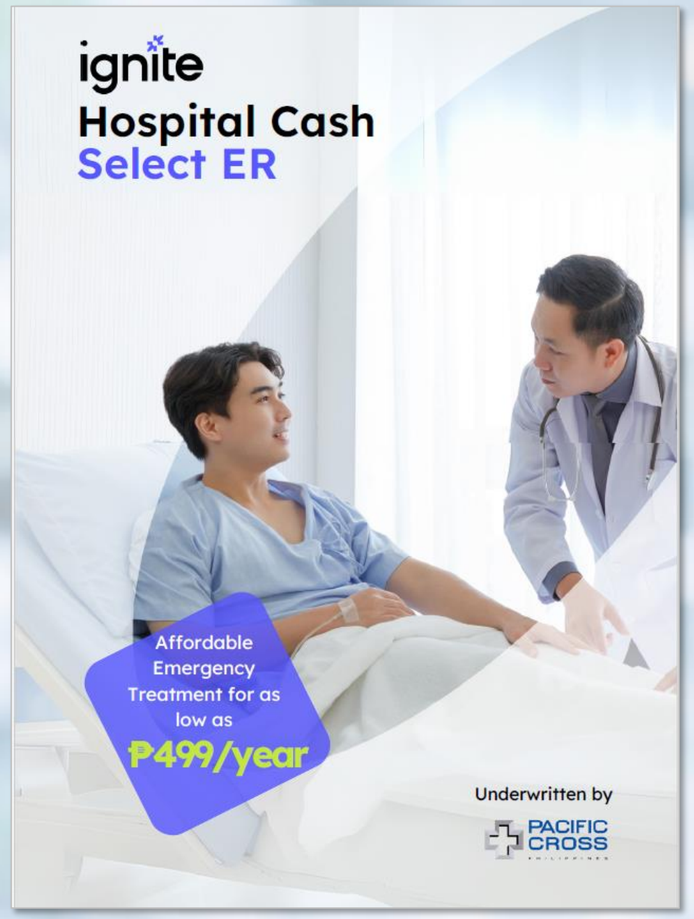
SELECT PREPAID | SUMMARY





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ACCREDITED NETWORK & AVAILMENT PROCESS

- No cash outlay Emergency Room
- ER IP & OP via reimbursement
- Claims form

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Accredited Network Updates

- Continuous growth and expansion of PCPH accredited network -

PROVIDERS	NUMBER			AAGR*
	2021	2022	2023	
Hospitals	347	376	400	6%
Clinics	530	630	727	16%
Doctor Network	18,911	21,471	27,568	19%
Doctors / Specialists	11,369	12,435	15,210	9%

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*Average Annual Growth Rate
Data is As Of January 5, 2024

No-Cash-Outlay Emergency Room Treatment (Select ER)

1

Insured to proceed to a PC accredited medical provider's* E.R. Department

2

Insured to present an SMS or E-mail confirmation from their mobile phones and a valid identification card for verification purposes. If no proof of coverage or any message confirmation from PC, Insured to inform the hospital personnel that you are availing under PC and to call PC hotline for verification and for manual approval request.

3

Insured to present valid ID (e.g., company ID, SSS ID, driver's license, or other ID cards bearing his photo and signature)

4

PC to conduct policy and benefit verification upon receipt of call from the hospital personnel. Once verified, PC to provide manual approval and coverage limit to the hospital personnel and to also inform that if the emergency out-patient availment leads to confinement, manual approval provided will be voided.

5

Proceed to laboratory tests and/or treatments

6

Insured to sign necessary documents and will be discharged upon settlement of any amount in excess of the E.R. benefit limit at the hospital cashier.

A copy of the accredited providers' list is available for download from our website (www.pacificcross.com.ph). You may also request a soft copy from our Customer Service Department. Please e-mail client_services@pacificcross.com.ph.

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Reimbursement Emergency In-Patient and Out-Patient Treatment

1

Proceed to any Accredited Hospital

2

Proceed to the needed emergency medical treatment

3

Pay the ER Hospital Bills and other Fees. Secure all requirements listed in the Notification of Claim (NOC) Form then file for reimbursement* with PC

IMPORTANT NOTE:

- FOR EMERGENCY OUT-PATIENT TREATMENT: The benefit is reimbursement of actual medical costs incurred in the emergency room.
- FOR EMERGENCY IN-PATIENT TREATMENT: The benefit is lump-sum cash assistance for emergency inpatient treatment, regardless of the incurred medical costs.

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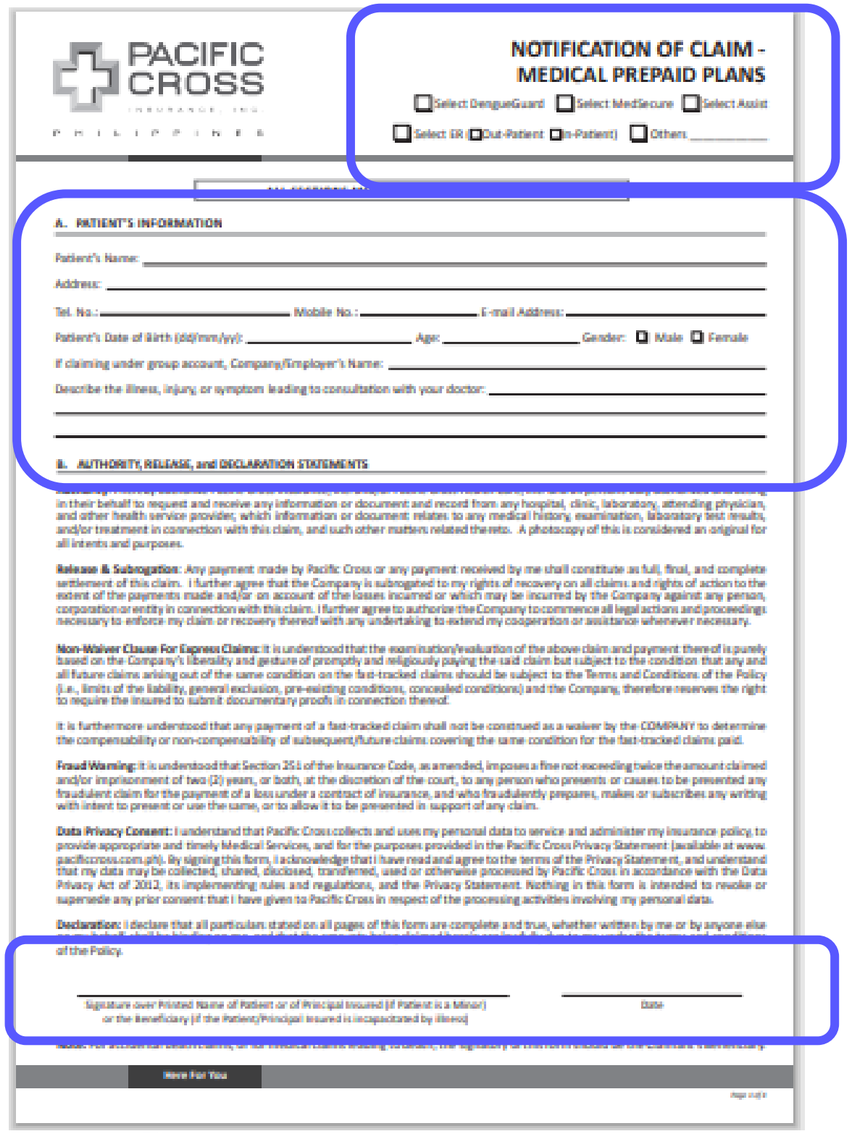
**Filing for reimbursement means submission of basic requirements as indicated in the Notification of Claim (NOC) Form.*

Notification of Claims (NOC) Form



PACIFIC CROSS
INSURANCE, INC.
PHILIPPINES

NOTIFICATION OF CLAIM - MEDICAL PREPAID PLANS

☐ Select DengueGuard ☐ Select MedSecure ☐ Select Assist

☐ Select ER (☐ Out-Patient ☐ In-Patient) ☐ Others _____

A. PATIENT'S INFORMATION

Patient's Name: _____

Address: _____

Tel. No.: _____ Mobile No.: _____ E-mail Address: _____

Patient's Date of Birth (dd/mm/yy): _____ Age: _____ Gender: ☐ Male ☐ Female

If claiming under group account, Company/Employer's Name: _____

Describe the illness, injury, or symptom leading to consultation with your doctor: _____

B. AUTHORITY, RELEASE, and DECLARATION STATEMENTS

in 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 claim, and such other matters related thereto. A photocopy of this is considered an original for all intents and purposes.

Release & Subrogation: Any payment made by Pacific Cross or any payment received by me shall constitute as full, final, and complete settlement of this claim. I further agree that the Company is subrogated to my rights of recovery on all claims and rights of action to the extent of the payments made and/or on account of the losses incurred or which may be incurred by the Company against any person, corporation or entity in connection with this claim. I further agree to authorize the Company to commence all legal actions and proceedings necessary to enforce my claim or recovery thereof with any undertaking to extend my cooperation or assistance whenever necessary.

Non-Waiver Clause For Express Claims: It is understood that the examination/evaluation of the above claim and payment thereof is purely based on the Company's liberality and gesture of promptly and religiously paying the said claim but subject to the condition that any and all future claims arising out of the same condition on the fast-tracked claims should be subject to the Terms and Conditions of the Policy (i.e., limits of the liability, general exclusion, pre-existing conditions, concealed conditions) and the Company, therefore reserves the right to require the Insured to submit documentary proofs in connection thereof.

It is furthermore understood that any payment of a fast-tracked claim shall not be construed as a waiver by the COMPANY to determine the compensability or non-compensability of subsequent/future claims covering the same condition for the fast-tracked claims paid.

Fraud Warning: It is understood that Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim.

Data Privacy Consent: I understand that Pacific Cross collects and uses my personal data to service and administer my insurance policy, to provide appropriate and timely Medical Services, and for the purposes provided in the Pacific Cross Privacy Statement (available at www.pacificcross.com.ph). By signing this form, I acknowledge that I have read and agree to the terms of the Privacy Statement, and understand that my data may be collected, shared, disclosed, transferred, used or otherwise processed by Pacific Cross in accordance with the Data Privacy Act of 2012, its implementing rules and regulations, and the Privacy Statement. Nothing in this form is intended to revoke or supersede any prior consent that I have given to Pacific Cross in respect of the processing activities involving my personal data.

Declaration: I declare that all particulars stated on all pages of this form are complete and true, whether written by me or by anyone else

of the Policy.

_____ _____

Signature over Printed Name of Patient or of Principal Insured (if Patient is a Minor) or the Beneficiary (if the Patient/Principal Insured is incapacitated by illness) | Date

Here For You

REMINDER: All Sections must be completely filled out.

NOTIFICATION OF CLAIM - MEDICAL PREPAID PLANS

☐ Select DengueGuard ☐ Select MedSecure ☐ Select Assist

☐ Select ER (☐ Out-Patient ☐ In-Patient) ☐ Others _____

A. PATIENT'S INFORMATION

Patient's Name: _____

Address: _____

Tel. No.: _____ Mobile No.: _____ E-mail Address: _____

Patient's Date of Birth (dd/mm/yy): _____ Age: _____ Gender: ☐ Male ☐ Female

If claiming under group account, Company/Employer's Name: _____

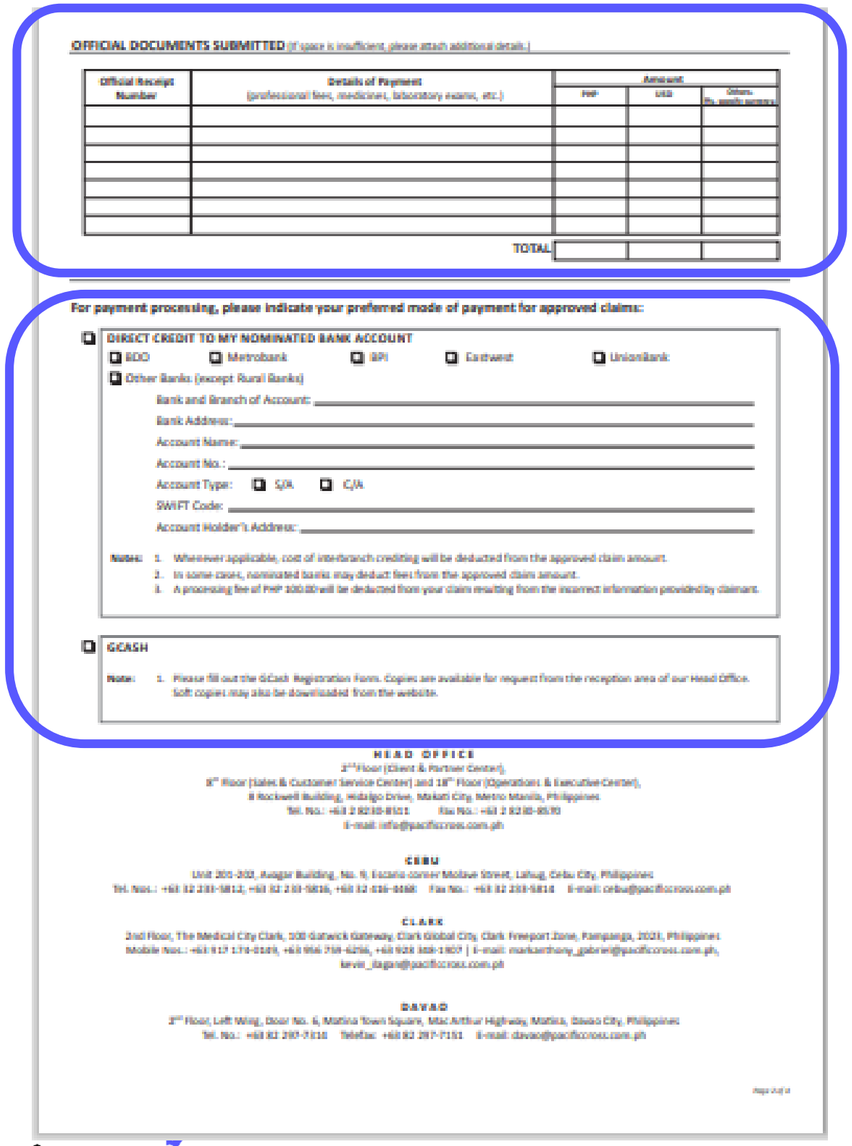
Describe the illness, injury, or symptom leading to consultation with your doctor: _____

_____ _____

Signature over Printed Name of Patient or of Principal Insured (if Patient is a Minor) or the Beneficiary (if the Patient/Principal Insured is incapacitated by illness) | Date

Note: For accidental death claims, or for medical claims leading to death, the signatory of this form should be the Claimant's Beneficiary.

Notification of Claims (NOC) Form



OFFICIAL DOCUMENTS SUBMITTED (If space is insufficient, please attach additional details.)

Official Receipt Number	Details of Payment (professional fees, medicines, laboratory exams, etc.)	Amount		
		PHP	USD	Others. Pls. specify currency.

For payment processing, please indicate your preferred mode of payment for approved claims:

❑ **DIRECT CREDIT TO MY NOMINATED BANK ACCOUNT**

❑ BDO ❑ Metrobank ❑ BPI ❑ Eastwest ❑ UnionBank

❑ Other Banks (except Rural Banks)

Bank and Branch of Account: _____

Bank Address: _____

Account Name: _____

Account No.: _____

Account Type: ❑ S/A ❑ C/A

SWIFT Code: _____

Account Holder's Address: _____

Notes:
1. Whenever applicable, cost of interbranch crediting will be deducted from the approved claim amount.
2. In some cases, nominated banks may deduct fees from the approved claim amount.
3. A processing fee of PHP 100.00 will be deducted from your claim resulting from the incorrect information provided by claimant.

❑ **GCASH**

Note: 1. Please fill out the GCash Registration Form. Copies are available for request from the reception area of our Head Office. Soft copies may also be downloaded from the website.

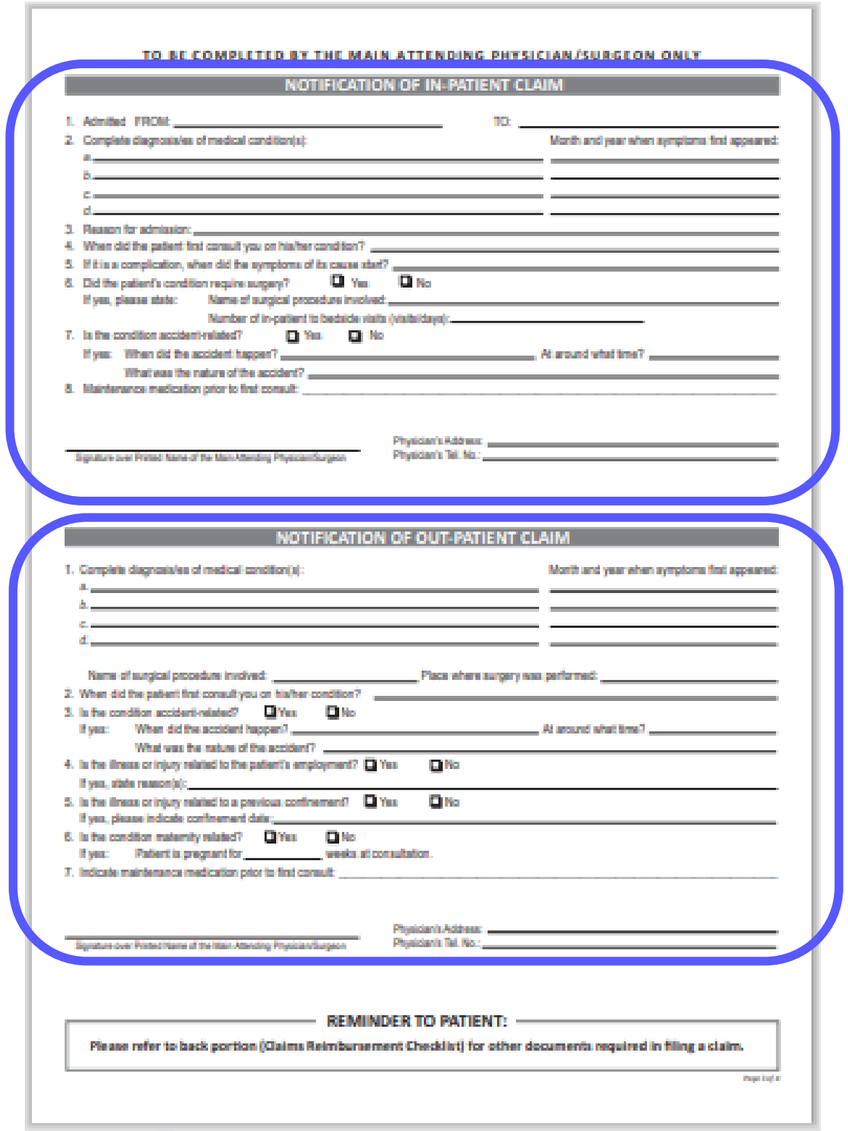
HEAD OFFICE
2nd Floor (Client & Partner Center),
8th Floor (Sales & Customer Service Center) and 18th Floor (Operations & Executive Center),
8 Rockwell Building, Hidalgo Drive, Makati City, Metro Manila, Philippines
Tel. Nos.: +63 2 8230-8151 Fax No.: +63 2 8230-8570
E-mail: info@pacificcross.com.ph

CEBU
Unit 201-202, Avagar Building, No. 9, Escario corner Molave Street, Lahug, Cebu City, Philippines
Tel. Nos.: +63 32 233-5812; +63 32 233-5816, +63 32 416-8488 Fax No.: +63 32 233-5814 E-mail: cebu@pacificcross.com.ph

CLARK
2nd Floor, The Medical City Clark, 300 Gateway Gateway, Clark Global City, Clark Freeport Zone, Pampanga, 2023, Philippines
Mobile Nos.: +63 917 174-0169, +63 956 759-6256, +63 928 888-1807 | E-mail: markanthony_gabriel@pacificcross.com.ph, kevin_ilagan@pacificcross.com.ph

DAVAO
2nd Floor, Left Wing, Door No. 6, Matina Town Square, MacArthur Highway, Matina, Davao City, Philippines
Tel. No.: +63 82 297-7110 Telefax: +63 82 297-7151 E-mail: davao@pacificcross.com.ph

Notification of Claims (NOC) Form



TO BE COMPLETED BY THE MAIN ATTENDING PHYSICIAN/SURGEON ONLY

NOTIFICATION OF IN-PATIENT CLAIM

1. Admitted FROM: _____ TO: _____
2. Complete diagnosis/es of medical condition(s): Month and year when symptoms first appeared:
   a. _____
   b. _____
   c. _____
   d. _____
3. Reason for admission: _____
4. When did the patient first consult you on his/her condition? _____
5. If it is a complication, when did the symptoms of its cause start? _____
6. Did the patient's condition require surgery? ❑ Yes ❑ No
   If yes, please state: Name of surgical procedure involved: _____
   Number of in-patient to bedside visits (visits/days): _____
7. Is the condition accident-related? ❑ Yes ❑ No
   If yes: When did the accident happen? _____ At around what time? _____
   What was the nature of the accident? _____
8. Maintenance medication prior to first consult: _____

_____ Physician's Address: _____
Signature over Printed Name of the Main Attending Physician/Surgeon Physician's Tel. No.: _____

NOTIFICATION OF OUT-PATIENT CLAIM

1. Complete diagnosis/es of medical condition(s): Month and year when symptoms first appeared:
   a. _____
   b. _____
   c. _____
   d. _____

   Name of surgical procedure involved: _____ Place where surgery was performed: _____
2. When did the patient first consult you on his/her condition? _____
3. Is the condition accident-related? ❑ Yes ❑ No
   If yes: When did the accident happen? _____ At around what time? _____
   What was the nature of the accident? _____
4. Is the illness or injury related to the patient's employment? ❑ Yes ❑ No
   If yes, state reason(s): _____
5. Is the illness or injury related to a previous confinement? ❑ Yes ❑ No
   If yes, please indicate confinement date: _____
6. Is the condition maternity related? ❑ Yes ❑ No
   If yes: Patient is pregnant for _____ weeks at consultation.
7. Indicate maintenance medication prior to first consult: _____

_____ Physician's Address: _____
Signature over Printed Name of the Main Attending Physician/Surgeon Physician's Tel. No.: _____

REMINDER TO PATIENT:

Please refer to back portion (Claims Reimbursement Checklist) for other documents required in filing a claim.

NOTIFICATION OF IN-PATIENT CLAIM

1. Admitted FROM: _____ TO: _____
2. Complete diagnosis/es of medical condition(s): Month and year when symptoms first appeared:

NOTIFICATION OF OUT-PATIENT CLAIM

1. Complete diagnosis/es of medical condition(s): Month and year when symptoms first appeared:
   a. _____
   b. _____
   c. _____
   d. _____

   Name of surgical procedure involved: _____ Place where surgery was performed: _____
2. When did the patient first consult you on his/her condition? _____
3. Is the condition accident-related? ❑ Yes ❑ No
   If yes: When did the accident happen? _____ At around what time? _____
   What was the nature of the accident? _____
4. Is the illness or injury related to the patient's employment? ❑ Yes ❑ No
   If yes, state reason(s): _____
5. Is the illness or injury related to a previous confinement? ❑ Yes ❑ No
   If yes, please indicate confinement date: _____
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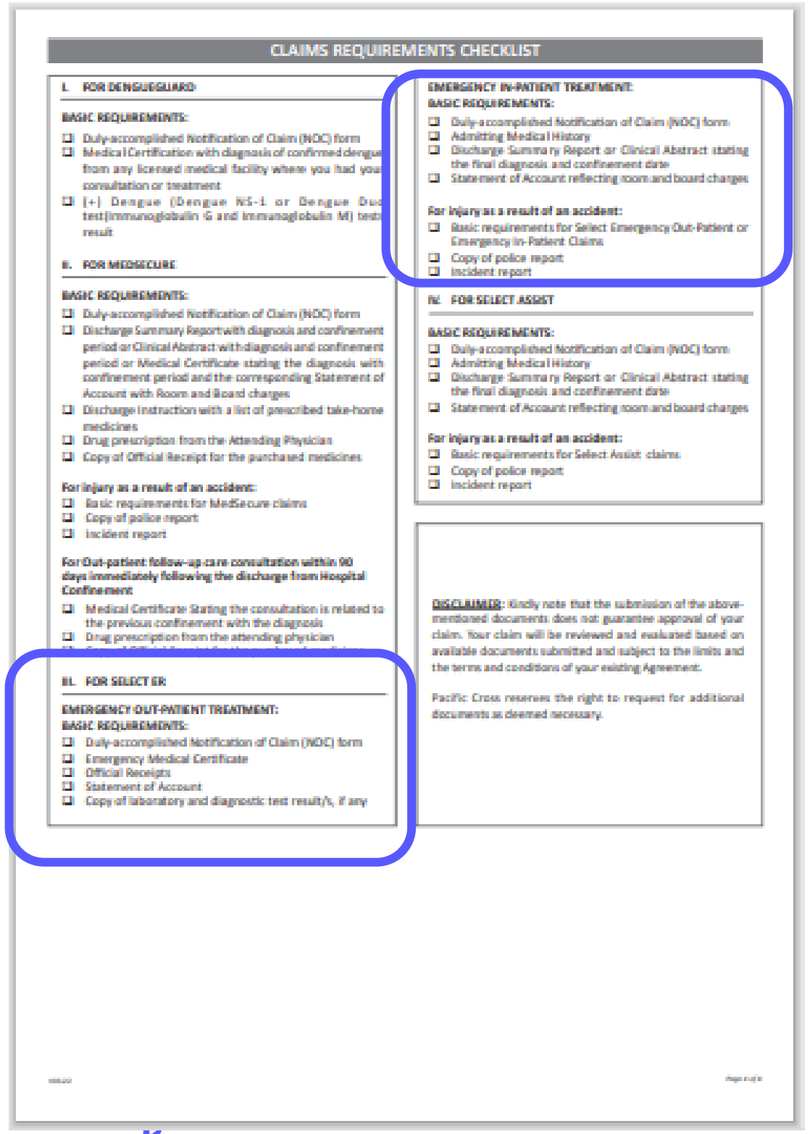
   If yes: Patient is pregnant for _____ weeks at consultation.
7. Indicate maintenance medication prior to first consult: _____

_____ Physician's Address: _____
Signature over Printed Name of the Main Attending Physician/Surgeon Physician's Tel. No.: _____

REMINDER: ***To be completed by the main attending physician/surgeon only***

Notification of Claims (NOC) Form



CLAIMS REQUIREMENTS CHECKLIST

I. FOR DENGUEGUARD

BASIC REQUIREMENTS:
- ☐ Duly-accomplished Notification of Claim (NOC) form
- ☐ Medical Certification with diagnosis of confirmed dengue from any licensed medical facility where you had your consultation or treatment
- ☐ (+) Dengue (Dengue NS-1 or Dengue Duo test/Immunoglobulin G and Immunoglobulin M) test result

II. FOR MEDSECURE

BASIC REQUIREMENTS:
- ☐ Duly-accomplished Notification of Claim (NOC) form
- ☐ Discharge Summary Report with diagnosis and confinement period or Clinical Abstract with diagnosis and confinement period or Medical Certificate stating the diagnosis with confinement period and the corresponding Statement of Account with Room and Board charges
- ☐ Discharge Instruction with a list of prescribed take-home medicines
- ☐ Drug prescription from the Attending Physician
- ☐ Copy of Official Receipt for the purchased medicines

For injury as a result of an accident:
- ☐ Basic requirements for MedSecure claims
- ☐ Copy of police report
- ☐ Incident report

For Out-patient follow-up care consultation within 90 days immediately following the discharge from Hospital Confinement
- ☐ Medical Certificate Stating the consultation is related to the previous confinement with the diagnosis
- ☐ Drug prescription from the attending physician

III. FOR SELECT ER

EMERGENCY OUT-PATIENT TREATMENT:
BASIC REQUIREMENTS:
- ☐ Duly-accomplished Notification of Claim (NOC) form
- ☐ Emergency Medical Certificate
- ☐ Official Receipts
- ☐ Statement of Account
- ☐ Copy of laboratory and diagnostic test result/s, if any

EMERGENCY IN-PATIENT TREATMENT:
BASIC REQUIREMENTS:
- ☐ Duly-accomplished Notification of Claim (NOC) form
- ☐ Admitting Medical History
- ☐ Discharge Summary Report or Clinical Abstract stating the final diagnosis and confinement date
- ☐ Statement of Account reflecting room and board charges

For injury as a result of an accident:
- ☐ Basic requirements for Select Emergency Out-Patient or Emergency In-Patient Claims
- ☐ Copy of police report
- ☐ Incident report

IV. FOR SELECT ASSIST

BASIC REQUIREMENTS:
- ☐ Duly-accomplished Notification of Claim (NOC) form
- ☐ Admitting Medical History
- ☐ Discharge Summary Report or Clinical Abstract stating the final diagnosis and confinement date
- ☐ Statement of Account reflecting room and board charges

For injury as a result of an accident:
- ☐ Basic requirements for Select Assist claims
- ☐ Copy of police report
- ☐ Incident report

DISCLAIMER: Kindly note that the submission of the above-mentioned documents does not guarantee approval of your claim. Your claim will be reviewed and evaluated based on available documents submitted and subject to the limits and the terms and conditions of your existing Agreement.

Pacific Cross reserves the right to request for additional documents as deemed necessary.

Select ER Document Requirements

III. FOR SELECT ER

EMERGENCY OUT-PATIENT TREATMENT:

BASIC REQUIREMENTS:
- ❑ Duly-accomplished Notification of Claim (NOC) form
- ❑ Emergency Medical Certificate
- ❑ Official Receipts
- ❑ Statement of Account
- ❑ Copy of laboratory and diagnostic test result/s, if any

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BASIC REQUIREMENTS:
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- ❑ Admitting Medical History
- ❑ Discharge Summary Report or Clinical Abstract stating the final diagnosis and confinement date
- ❑ Statement of Account reflecting room and board charges

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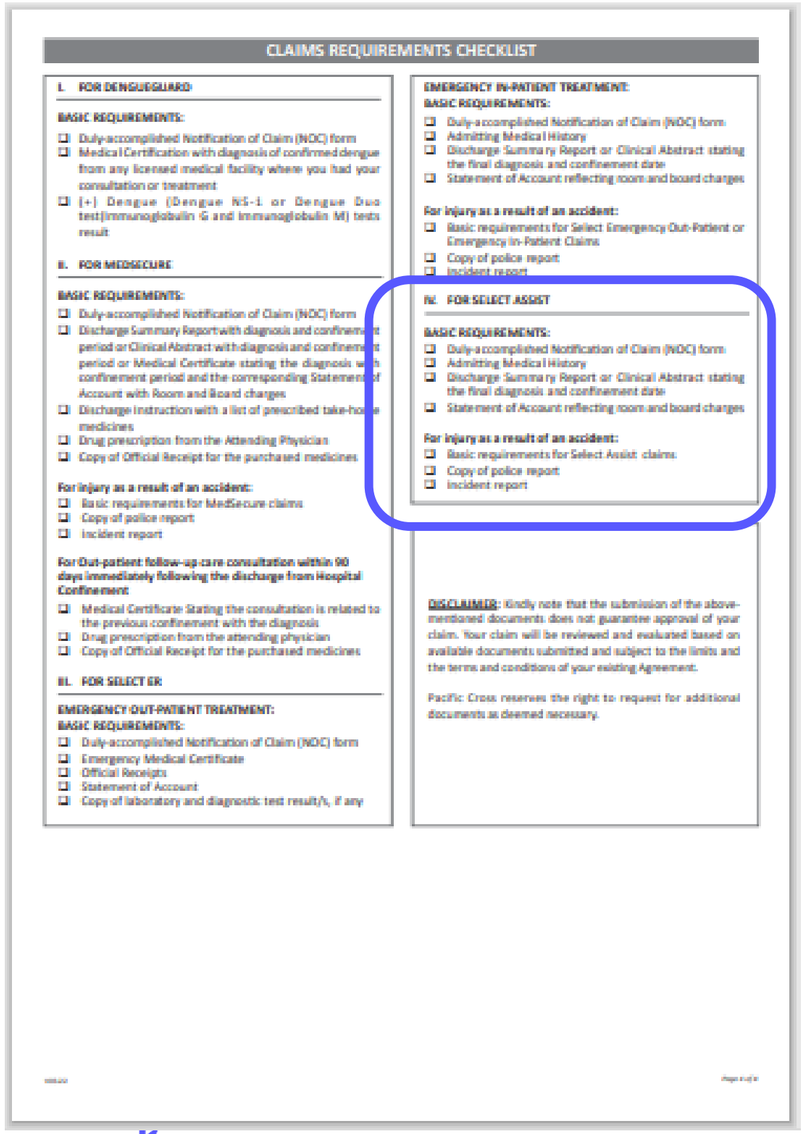
- ❑ Copy of police report
- ❑ Incident report

Notification of Claims (NOC) Form



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- ☐ Official Receipts
- ☐ Statement of Account
- ☐ Copy of laboratory and diagnostic test result/s, if any

EMERGENCY IN-PATIENT TREATMENT:
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- ☐ Admitting Medical History
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- ☐ Statement of Account reflecting room and board charges

For injury as a result of an accident:
- ☐ Basic requirements for Select Emergency Out-Patient or Emergency In-Patient Claims
- ☐ Copy of police report
- ☐ Incident report

IV. FOR SELECT ASSIST

BASIC REQUIREMENTS:
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For injury as a result of an accident:
- ☐ Basic requirements for Select Assist claims
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DISCLAIMER: Kindly note that the submission of the above-mentioned documents does not guarantee approval of your claim. Your claim will be reviewed and evaluated based on available documents submitted and subject to the limits and the terms and conditions of your existing Agreement.

Pacific Cross reserves the right to request for additional documents as deemed necessary.

Select Assist Document Requirements

IV. FOR SELECT ASSIST

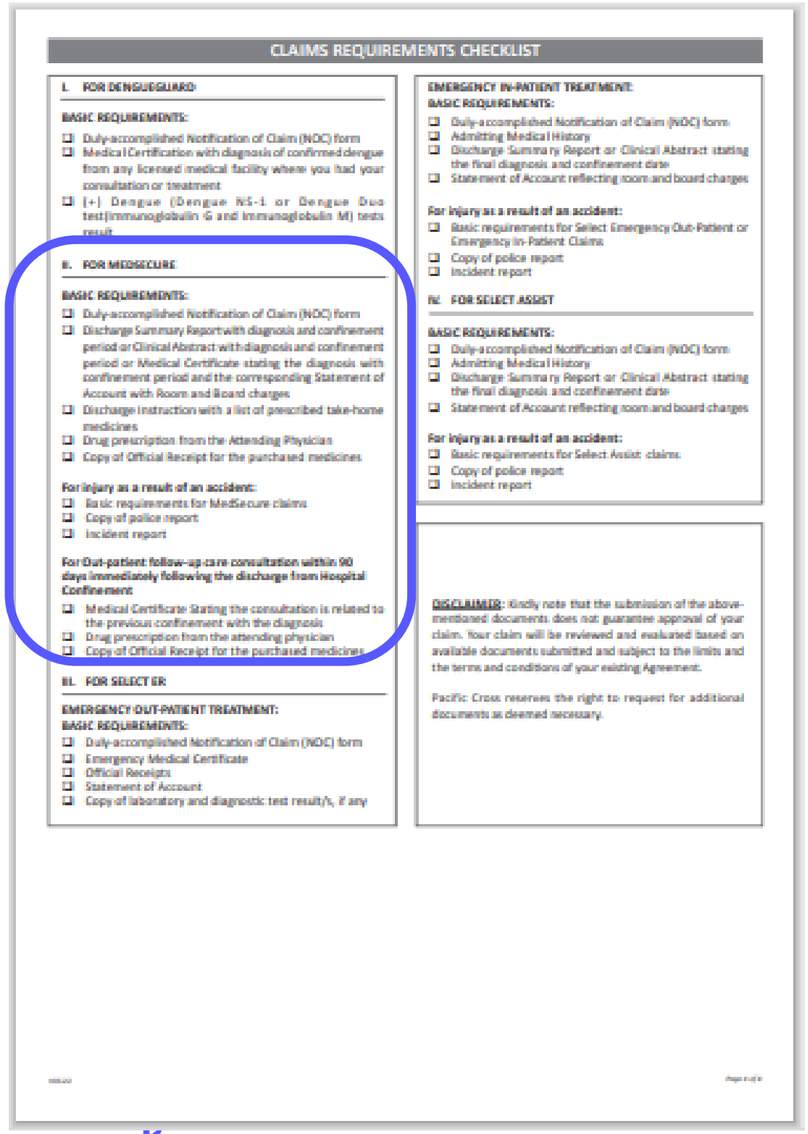
BASIC REQUIREMENTS:

- ❑ Duly-accomplished Notification of Claim (NOC) form
- ❑ Admitting Medical History
- ❑ Discharge Summary Report or Clinical Abstract stating the final diagnosis and confinement date
- ❑ Statement of Account reflecting room and board charges

For injury as a result of an accident:

- ❑ Basic requirements for Select Assist claims
- ❑ Copy of police report
- ❑ Incident report

Notification of Claims (NOC) Form



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- ☐ Duly-accomplished Notification of Claim (NOC) form
- ☐ Medical Certification with diagnosis of confirmed dengue from any licensed medical facility where you had your consultation or treatment
- ☐ (+) Dengue (Dengue NS-1 or Dengue Duo test/Immunoglobulin G and Immunoglobulin M) tests result

II. FOR MEDSECURE

BASIC REQUIREMENTS:
- ☐ Duly-accomplished Notification of Claim (NOC) form
- ☐ Discharge Summary Report with diagnosis and confinement period or Clinical Abstract with diagnosis and confinement period or Medical Certificate stating the diagnosis with confinement period and the corresponding Statement of Account with Room and Board charges
- ☐ Discharge Instruction with a list of prescribed take-home medicines
- ☐ Drug prescription from the Attending Physician
- ☐ Copy of Official Receipt for the purchased medicines

For injury as a result of an accident:
- ☐ Basic requirements for MedSecure claims
- ☐ Copy of police report
- ☐ Incident report

For Out-patient follow-up care consultation within 90 days immediately following the discharge from Hospital Confinement
- ☐ Medical Certificate Stating the consultation is related to the previous confinement with the diagnosis
- ☐ Drug prescription from the attending physician
- ☐ Copy of Official Receipt for the purchased medicines

III. FOR SELECT ER

EMERGENCY OUT-PATIENT TREATMENT:
BASIC REQUIREMENTS:
- ☐ Duly-accomplished Notification of Claim (NOC) form
- ☐ Emergency Medical Certificate
- ☐ Official Receipts
- ☐ Statement of Account
- ☐ Copy of laboratory and diagnostic test result/s, if any

EMERGENCY IN-PATIENT TREATMENT:
BASIC REQUIREMENTS:
- ☐ Duly-accomplished Notification of Claim (NOC) form
- ☐ Admitting Medical History
- ☐ Discharge Summary Report or Clinical Abstract stating the final diagnosis and confinement date
- ☐ Statement of Account reflecting room and board charges

For injury as a result of an accident:
- ☐ Basic requirements for Select Emergency Out-Patient or Emergency In-Patient Claims
- ☐ Copy of police report
- ☐ Incident report

IV. FOR SELECT ASSIST

BASIC REQUIREMENTS:
- ☐ Duly-accomplished Notification of Claim (NOC) form
- ☐ Admitting Medical History
- ☐ Discharge Summary Report or Clinical Abstract stating the final diagnosis and confinement date
- ☐ Statement of Account reflecting room and board charges

For injury as a result of an accident:
- ☐ Basic requirements for Select Assist claims
- ☐ Copy of police report
- ☐ Incident report

DISCLAIMER: Kindly note that the submission of the above-mentioned documents does not guarantee approval of your claim. Your claim will be reviewed and evaluated based on available documents submitted and subject to the limits and the terms and conditions of your existing Agreement.

Pacific Cross reserves the right to request for additional documents as deemed necessary.

Select MedSecure Document Requirements

II. FOR MEDSECURE

BASIC REQUIREMENTS:

- ❑ Duly-accomplished Notification of Claim (NOC) form
- ❑ Discharge Summary Report with diagnosis and confinement period or Clinical Abstract with diagnosis and confinement period or Medical Certificate stating the diagnosis with confinement period and the corresponding Statement of Account with Room and Board charges
- ❑ Discharge Instruction with a list of prescribed take-home medicines
- ❑ Drug prescription from the Attending Physician
- ❑ Copy of Official Receipt for the purchased medicines

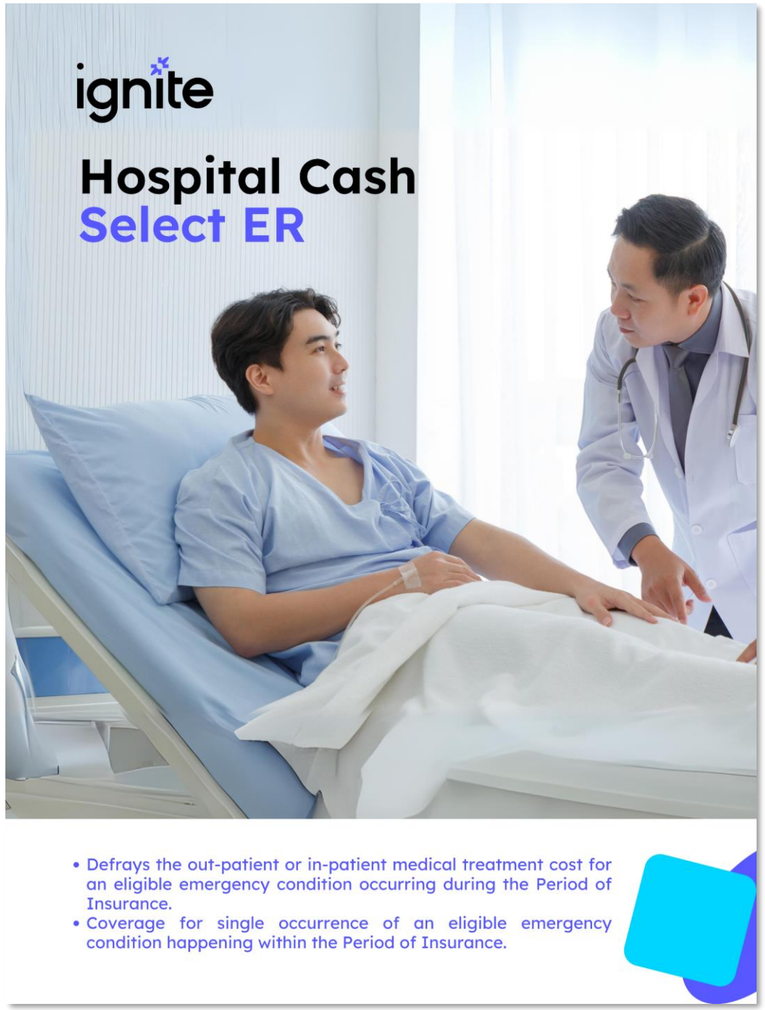
For injury as a result of an accident:

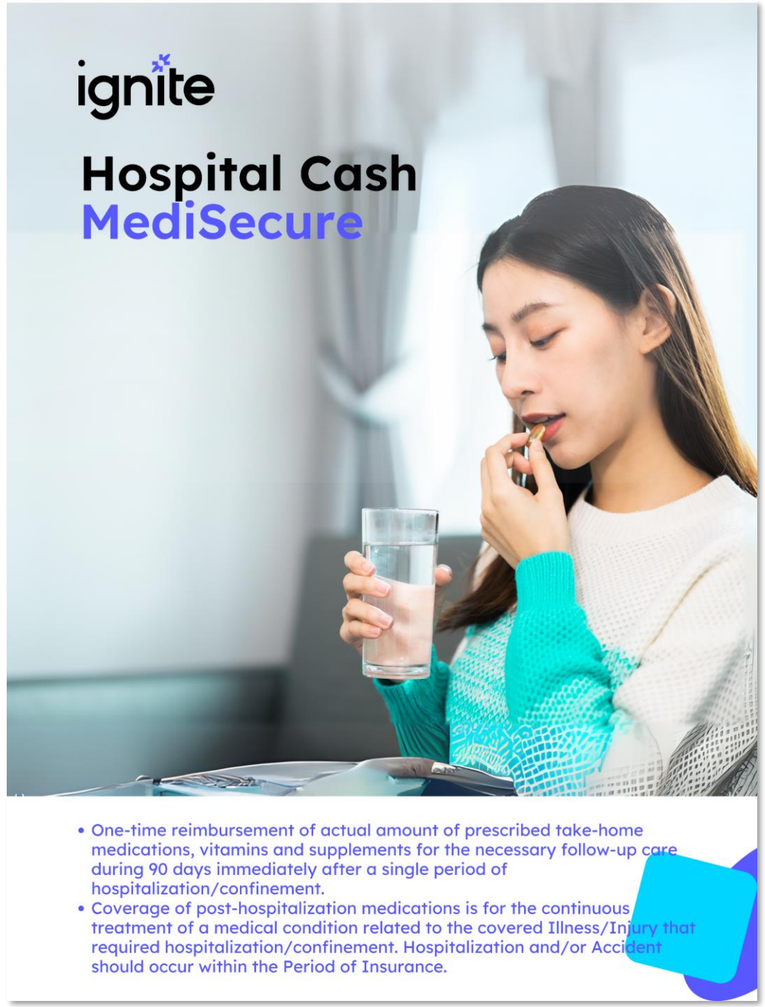
- ❑ Basic requirements for MedSecure claims
- ❑ Copy of police report
- ❑ Incident report

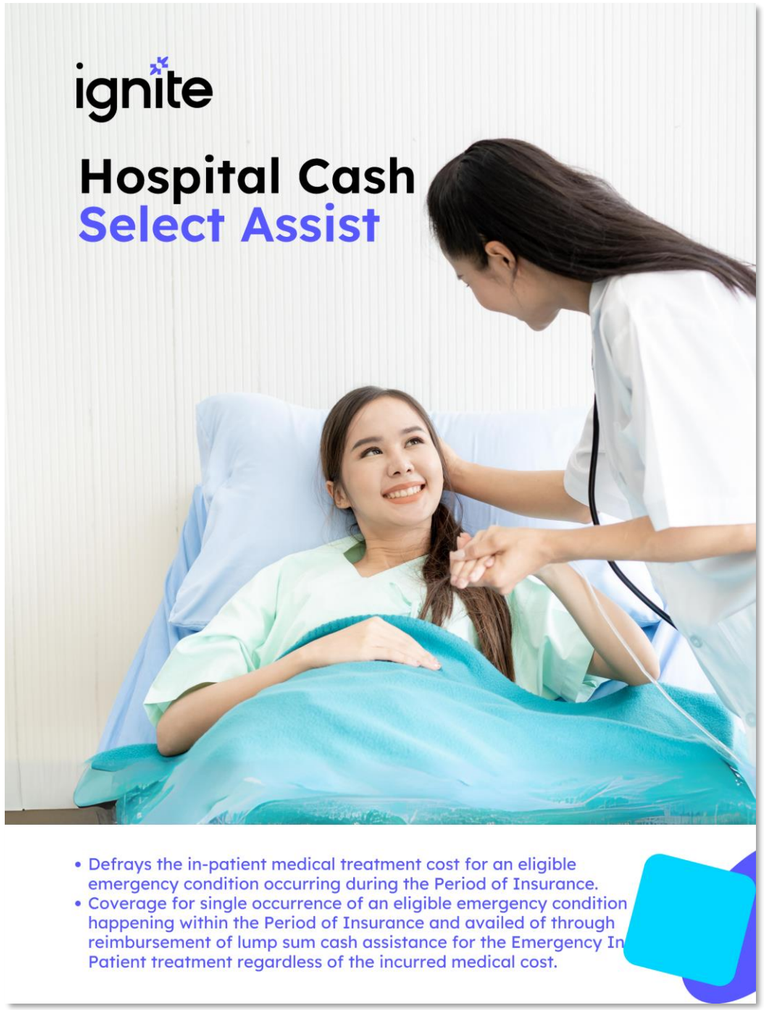
For Out-patient follow-up care consultation within 90 days immediately following the discharge from Hospital Confinement

- ❑ Medical Certificate Stating the consultation is related to the previous confinement with the diagnosis
- ❑ Drug prescription from the attending physician
- ❑ Copy of Official Receipt for the purchased medicines

Your Social Media Tools







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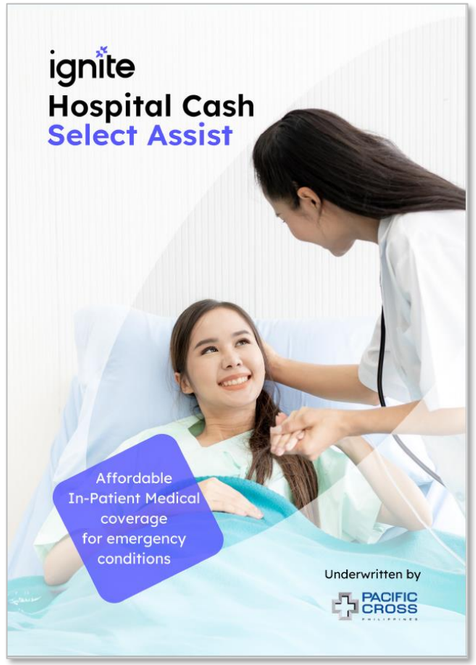
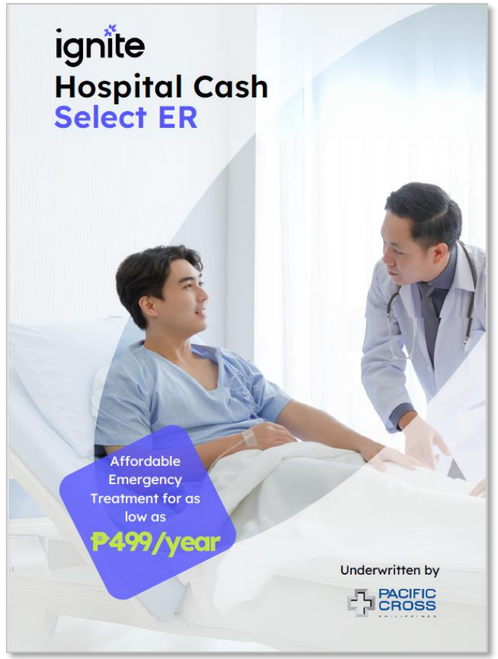
Product Brochures

with description and rates





Benefit highlights

- Defrays the in-patient medical treatment cost for an eligible emergency condition occurring during the Period of Insurance.
- Once the claim is approved, the limit is considered fully exhausted, and the Policy is automatically terminated.
- Effective Date is on the 7th day after successful registration.
- Coverage for single occurrence of an eligible emergency condition happening within the Period of Insurance and availed of through reimbursement of lump sum cash assistance for the Emergency In-Patient treatment regardless of the incurred medical cost.

The subject insured

- Issue Age at the time of Registration: **15 days - 65 years old**
- Waiting Period: **7 days**

Premiums

Select Assist	Maximum benefit	Premium
Plan A	₱10,000	₱1,499
Plan B	₱20,000	₱2,699
Plan C	₱30,000	₱3,899

Scan QR for payment

Limitations

- The next Period of Insurance for this Prepaid Plan is allowable after a 60-day interval from the time the Policy is terminated due to an approved claim. This interval will not apply for a 1-year Period of Insurance (i.e., the Policy was not terminated ahead of the expiry date.).
- This Prepaid Plan does not cover claims related to confinement purely for diagnostic purposes, epidemic/pandemic, congenital, STD, AIDS/HIV, Pregnancy, autoimmune conditions, mental or nervous/anxiety disorder, degenerative brain disorder, suicide and accidents resulting from hazardous activity or substance abuse, professional sports and contact sports, among others.
- Only 1 Plan Option per Period of Insurance is allowed.

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Benefit highlights

- Defrays the out-patient or in-patient medical treatment cost for an eligible emergency condition occurring during the Period of Insurance. Once claim is approved, the limit is considered fully exhausted, and Policy is automatically terminated.
- Coverage for single occurrence of an eligible emergency condition happening within the Period of Insurance and availed of through either:
  - Reimbursement or direct settlement of actual medical cost incurred in the Emergency Room Department of an accredited Hospital or
  - Reimbursement of lump sum cash assistance for the Emergency In-Patient treatment regardless of the incurred medical cost.

The subject insured

- Issue Age at the time of Registration: **15 days - 65 years old**
- Waiting Period: **7 days**

Premiums

Select ER	Maximum benefit	Premium
Plan A	₱5,000	₱499
Plan B	₱10,000	₱849
Plan C	₱20,000	₱1,199

Scan QR for payment

Limitations

- The next Period of Insurance for this Prepaid Plan is allowable after a 60-day interval from the time the Policy is terminated due to an approved claim. This interval will not apply for 1 year of Insurance.
- This Prepaid Plan does not cover claims related to confinement purely for diagnostic purposes, epidemic/pandemic, congenital, STD, AIDS/HIV, Pregnancy, autoimmune conditions, mental or nervous/anxiety disorder, degenerative brain disorder, suicide and accidents resulting from hazardous activity or substance abuse, professional sports and contact sports, among others.
- Only 1 Plan Option per Period of Insurance is allowed.

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Benefit highlights

- One-time reimbursement of actual amount of prescribed take-home medications, vitamins and supplements for the necessary follow-up care during 90 days immediately after a single period of hospitalization/confinement.
- Once claim is approved, the limit is considered fully exhausted, and Policy is automatically terminated.
- Effective Date is on the 15th day after successful registration.
- Coverage of post-hospitalization medications is for the continuous treatment of a medical condition related to the covered Illness/Injury that required hospitalization/confinement. Hospitalization and/or Accident should occur within the Period of Insurance.

The subject insured

- Issue Age at the time of Registration: **15 days - 60 years old**
- Waiting Period: **7 days**

Premiums

Select MedSecure	Maximum benefit	Premium
Plan A	₱2,000	₱549
Plan B	₱2,500	₱649
Plan C	₱5,000	₱950

Scan QR for payment

Limitations

- This Prepaid Plan does not cover claims related to confinement purely for diagnostic purposes, epidemic/pandemic, congenital, STD, AIDS/HIV, Pregnancy, autoimmune conditions, mental or nervous/anxiety disorder, degenerative brain disorder, suicide and accidents resulting from hazardous activity or substance abuse, professional sports and contact sports, among others.
- Only 1 Plan Option per Period of Insurance is allowed.

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Interim Offline Sales Flow: Hospital Cash Card

Customer	Referral Partner	Ignite Team	Pacific Cross

1 Client Selects type of Hospital Cash Card

2 Referral Partner sends payment link to client

3 Client pays premium and sends screen shot of proof of payment

4 Referral Partner enters the following information on Ignite Google Form:

- Referral Partner Name
- Referrer Code
- Client Name
- Client Birthday
- Plan Option
- Client Address
- Client e-mail address
- Client Mobile Number
- Guardian (for Minors)
- Gender
- Source of Funds
- Gov't ID Type
- Gov't ID Number
- Beneficiary Name
- Relationship to Insured
- Transaction Ref. Number
- Screenshot of Payment

5 Ignite Team Extracts daily from Google Form

6 Ignite Team checks for completion and submits to Pacific Cross

7 Pacific Cross Issues the Policy & e-cards and sends to client email

8 Client receives e-policy via email

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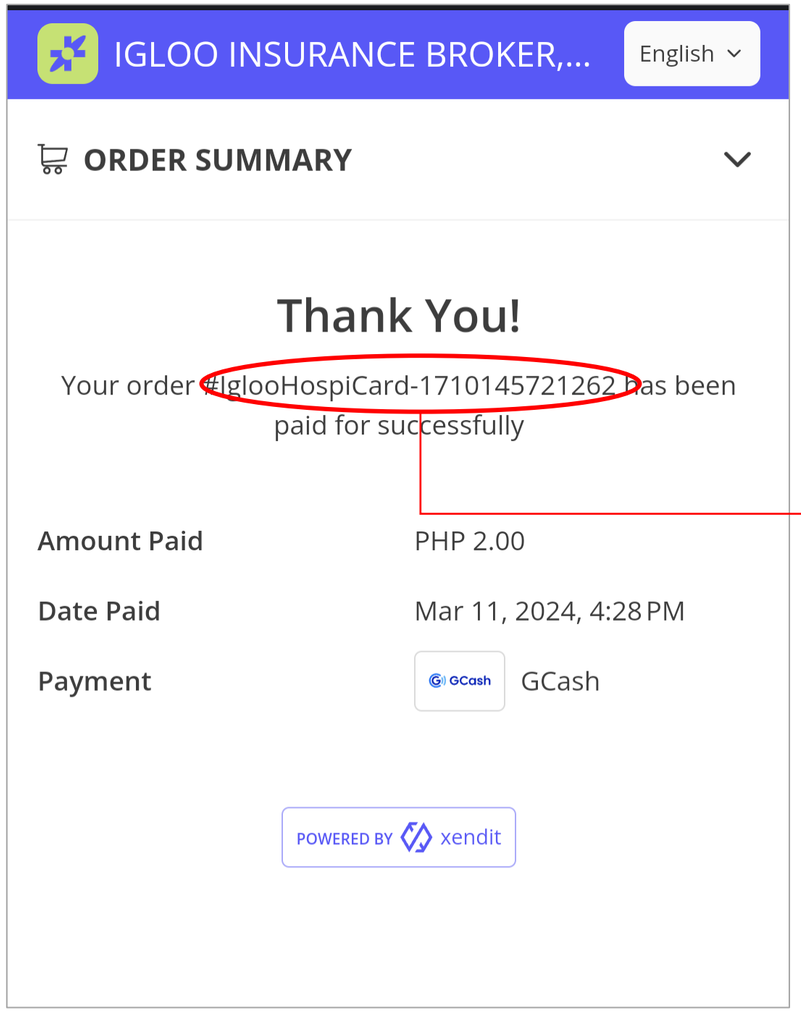
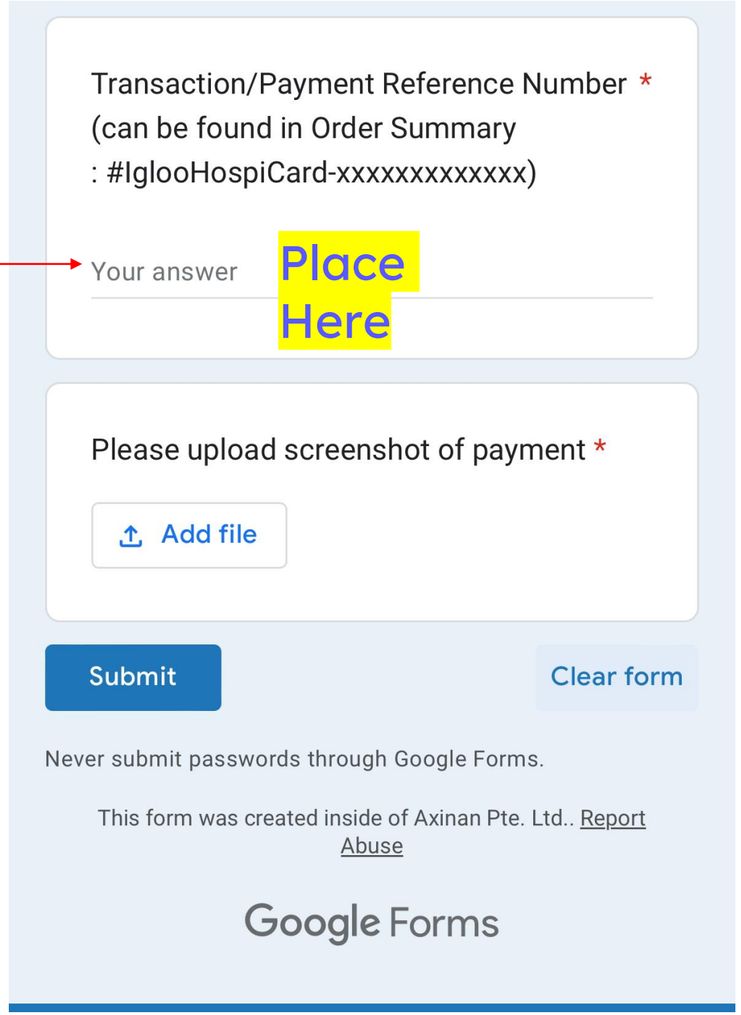
Entering Transaction ID





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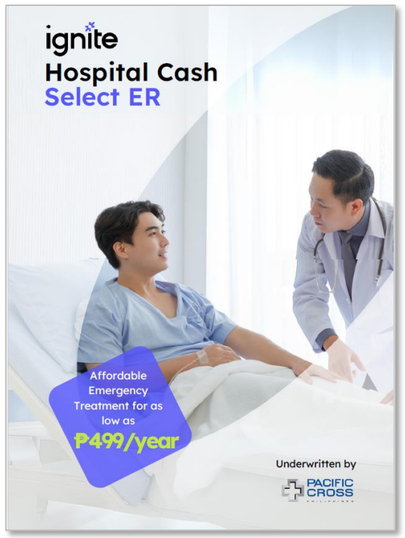
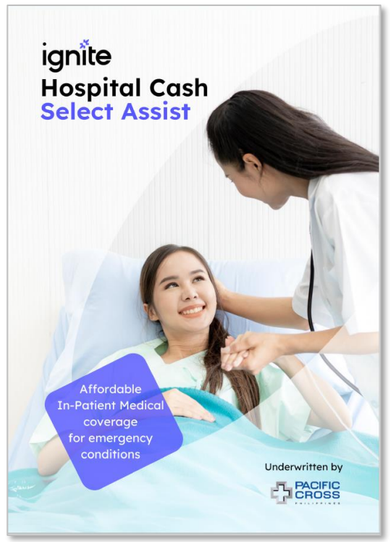
Referral Fee (of Net Premium)

Referral Partner	Ignite Manager	Managing Director	Managing Partner
12%	3%	2%	1%





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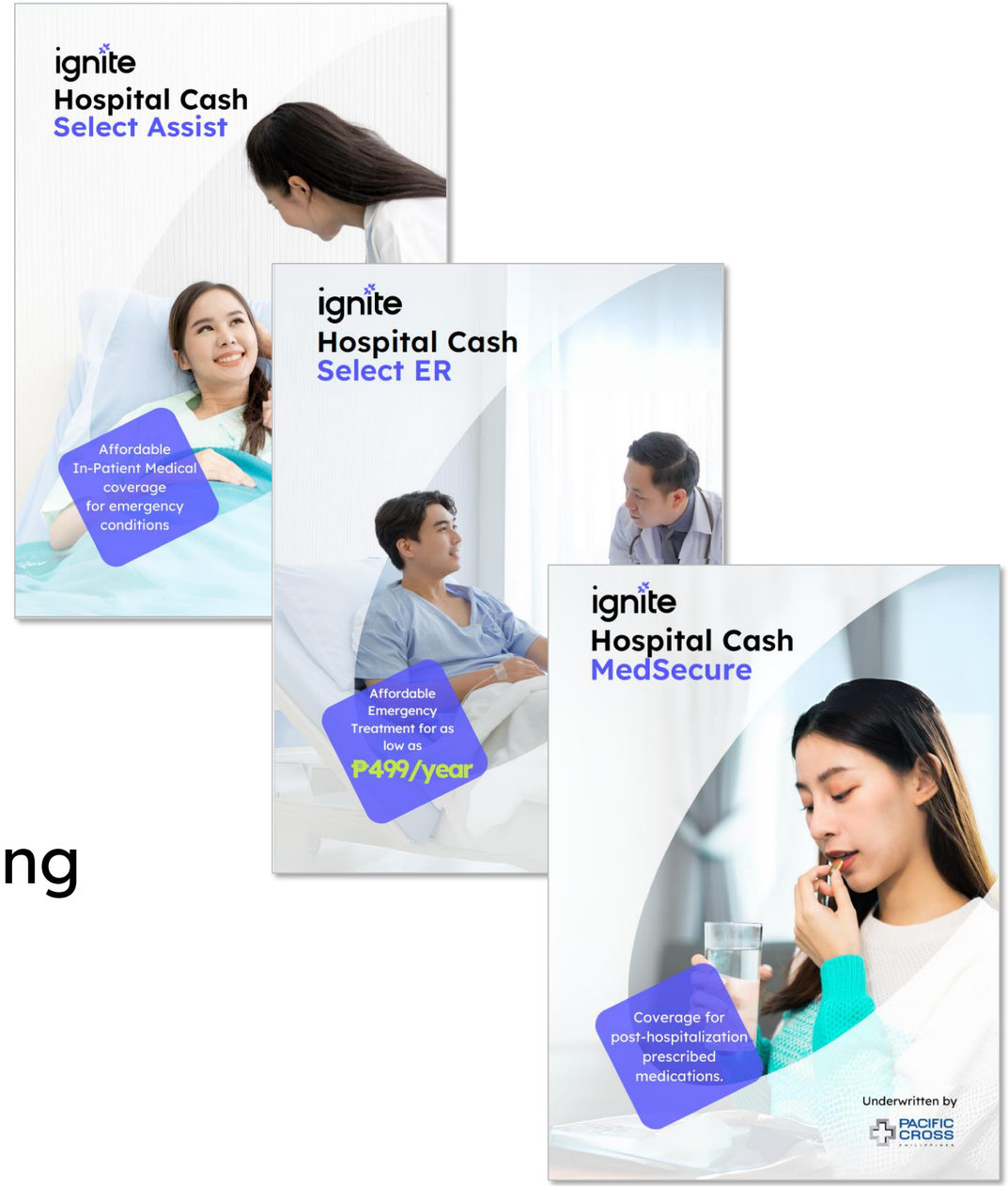
How to Maximize

- Position it as an “exit” product
- Combo Selling (3 in 1)
- Bundle with Personal Accident
- Integrate with your Core Products
- Community Selling / Household Selling



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Thank you!

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