



## Select Standard & Select Plus

### *Why Should You Choose the Select Medical Insurance Plan?*

- **Full reimbursement of medical expenses based on your coverage**  
When you choose Select, you are assured of swift, 100% reimbursement of eligible medical charges! Select provides a maximum coverage limit of up to Php3,000,000.
- **Your own choice of doctor, hospital and specialist**  
  
Select offers you complete freedom of choice. This means you can avail of the best medical treatment with your own choice of doctor, hospital, or specialist.
- **Comprehensive range of medical insurance benefits**  
Select offers a comprehensive range of in-patient and out-patient medical benefits, all designed to provide you the financial security and assistance you need in times of illness.
- **Emergency overseas coverage**  
Select also covers you for emergencies and accidents when you travel, so you can receive the best medical assistance anytime, anywhere in the world.
- **24-hour worldwide customer assistance and emergency hotline**  
Blue Cross, with its partnership with **International SOS**, has a worldwide network of alarm centers and full time medical professionals ready to help you 24 hours a day, 7 days a week, 365 days a year.
- **For Select Plus**  
An affordable peso plan that offers an aggregate limit of up to P 3 million renewable each year.

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*We want to give you something priceless --- peace of mind.*

## SELECT STANDARD & SELECT PLUS BENEFITS

Select Standard & Select Plus CORE BENEFITS	WARD	SEMI PRIVATE	PRIVATE	SUITE
<b>REIMBURSEMENT:</b> Your own choice of doctor or hospital. Full reimbursement of eligible medical expenses based on coverage. <b>Maximum Coverage</b> <b>Select Standard:</b> for each disability for the life of the insured <b>Select Plus:</b> aggregate limit per year	P 500,000	P 750,000	P 1,500,000	P 3,000,000
<b>BASIC HOSPITAL BENEFITS</b>				
<b>Room and Board</b> max 45 days per disability per year <b>Miscellaneous Hospital Expenses</b> for required drugs, laboratory and diagnostic procedures <b>Physician's Visit (non-surgical)</b> Daily visit fee to a limit of 45 days per disability, per year <b>Specialist's Fee</b> for 10 days for each disability to a daily limit of	As Charged	As Charged	As Charged	P 6,000 (per day) As Charged
	As Charged	As Charged	As Charged	As Charged
	P 550	P 750	P 1,500	P 3,000
	P 600	P 900	P 1,800	P 3,600
<b>CRITICAL CARE BENEFITS</b>				
<b>Intensive Care Unit, Coronary Unit</b> max 10 days per disability, per year	As Charged	As Charged	As Charged	As Charged
<b>SURGICAL BENEFITS</b>				
<b>Operating Theater Fee</b> <b>Surgeon's Fee</b> for each disability based on the Basic Surgical Schedule <b>Anaesthetist's Fee</b> not to exceed 30% of the approved Surgeon's Fee <b>Elective Surgery</b> scheduled surgery arranged by Blue Cross only within accredited network. Direct settlement of covered portion of confinement and treatment cost by Blue Cross (10-days notice must be given to Blue Cross by the Client). <b>Artificial Limb</b> including rental of mechanical devices (as approved by Blue Cross) excluding implantable devices	As Charged P 60,000  P 18,000  As Charged	As Charged P 90,000  P 30,000  As Charged	As Charged P 180,000  P 60,000  Direct Settlement of covered portion of confinement & treatment cost by Blue Cross.  As Charged	As Charged P 360,000  P 108,000  As Charged
<b>EMERGENCY BENEFITS</b>				
<b>Emergency Out-Patient</b> for emergency treatment provided by the out-patient department of a hospital or a licensed doctor in his clinic for a covered disability. Maximum limit per disability, per year. <b>Emergency Local Ambulance Service</b> to nearest facility <b>Worldwide Emergency Assistance Services</b> <sup>1</sup> 24 hours a day, 7 days a week, through International SOS, the integrated Global Assistance Company <b>Emergency Overseas Coverage</b> worldwide cover is included for 90 days only of accumulated (no more than 30 days per trip) stay or travel overseas during the Policy year. Reimbursement of medical expenses for overseas treatment of confinement will be based on currently applicable Philippine medical rates. <b>Emergency Medical Evacuation</b> <sup>2</sup> if traveling abroad, to nearest medical facility	P 3,000  As Charged  Included  Included  P 50,000	P 4,000  As Charged  Included  Included  P 50,000	P 5,000  As Charged  Included  Included  P 50,000	As Charged  As Charged  Included  Included  P 50,000
<b>VALUE ADDED BENEFITS</b>				
<b>Private Duty Nurse</b> when certified necessary by attending physician to a max of 5 days, post hospitalization - to a limit of <b>Companion Allowance</b> allowance given to companion max 5 days per given policy year <b>Sports Coverage</b> for recreational sports inc. skiing & scuba; exc. contact sports (subject to Policy limits)	P 600 (per day)  Not Available  Not Available	P 900 (per day)  Not Available  Not Available	P 1,800 (per day)  P 100 (per day) Included	As Charged  P 200 (per day) Included
<b>PERSONAL ACCIDENT BENEFIT</b>				
coverage for accidental death. covers new business clients age 16 to 60, renewable until age 65	P 25,000	P 50,000	P 75,000	P 100,000

<sup>1</sup> Blue Cross, through International SOS, will provide the assistance and advice for free but the client will be responsible for any third party charges incurred as a result of such advice or assistance unless otherwise specified elsewhere in the Policy.

<sup>2</sup> The actual cost of evacuation will be paid only if it is a result of a covered illness, accidental injury or death. Blue Cross retains the absolute right to decide whether the client's condition is sufficiently serious to warrant emergency evacuation. If and when the client's condition does not merit an evacuation as per Blue Cross assessment, and the client requests for such evacuation anyway, Blue Cross, through International SOS, will carry out the request. However, expenses shall be the client's responsibility.

OPTIONAL OUT-PATIENT BENEFITS	STANDARD		EXECUTIVE
BLUE CROSS PAYS 80% OF CLAIMED AMOUNT			
<b>Consultation in Doctor's Office</b> maximum 12 visits per year, limit of one per day	P 300 (per visit)		P 600 (per visit)
<b>Specialist Consultation</b> upon written referral from doctor, max 8 visits per year, limit of one per day	P 450 (per visit)		P 900 (per visit)
<b>Physiotherapist or Chiropractor</b> max 10 treatments per year, limit one per day	P 300 (per visit)		P 600 (per visit)
<b>Medicines and Drugs prescribed by a Doctor</b> for a covered condition or disability and procured from a recognized pharmacy. Limit per year	P 7,500		P 15,000
<b>Diagnostic, X-rays and Laboratory Tests</b> necessary for the treatment of a covered disability	P 6,000		P 12,000

# SELECT STANDARD & SELECT PLUS PREMIUMS

As of 1 March 2007

## ANNUAL PREMIUMS

SELECT STANDARD				
CORE BENEFITS (In-Patient and Emergency Benefits)				
AGE	WARD	S-PRIVATE	PRIVATE	SUITE
Child - 20	P 3,197	P 5,072	P 8,592	P 15,621
21 - 40	P 5,645	P 9,448	P 16,146	P 23,464
41 - 50	P 7,001	P 12,091	P 21,220	P 31,213
51 - 65	P 8,865	P 15,797	P 26,722	P 37,578

SELECT PLUS (Aggregate limit per year)				
CORE BENEFITS (In-Patient and Emergency Benefits)				
AGE	WARD	S-PRIVATE	PRIVATE	SUITE
Child - 20	P 3,872	P 6,243	P 10,216	P 21,302
21 - 40	P 6,900	P 11,576	P 19,023	P 31,128
41 - 50	P 8,773	P 15,351	P 27,802	P 41,464
51 - 65	P 10,960	P 19,189	P 39,810	P 51,716

## OPTIONAL BENEFITS

OUT-PATIENT BENEFITS			
Blue Cross pays 80% of reasonable, normal and customary fees. Reimbursement only.			
AGE	STANDARD	EXECUTIVE	
Child - 20	P 5,733	P 11,835	
21 - 40	P 5,385	P 11,442	
41 - 50	P 7,824	P 18,592	
51 - 65	P 9,773	P 24,209	

ADDITIONAL PERSONAL ACCIDENT COVERAGE				
Coverage for accidental death. Occupational Class I (Standard Risk).				
COVERAGE	WARD	S-PRIVATE	PRIVATE	SUITE
500,000	P 835	P 835	P 835	P 835
1,000,000	P 1,670	P 1,670	P 1,670	P 1,670

Premiums of other occupational classifications are available upon request.

## DISCOUNT OPTIONS

DISCOUNT OPTIONS				
80/20 co-payment option. Blue Cross pays 80% of claimed amount (applicable to Core Benefits only).	WARD	S-PRIVATE	PRIVATE	SUITE
	25% Discount	25% Discount	25% Discount	25% Discount

  

GROUP DISCOUNTS		
No. of Members:	7-15	16 or more
Discount:	5%	10%

Members mean Principal and eligible Dependents. Discounts are subject to Underwriting Guidelines. Premiums are in peso and inclusive of taxes. Individual and family premiums are available in annual and semi-annual modes of payment. Premiums may change subject to the results of medical evaluation of application form.

## MODE OF PAYMENT

Payment may be made through the following:

- Cash
- Check (Payable to Blue Cross Insurance, Inc.)
- Credit Card: AMX, VISA, Mastercard, Diners
- Bills Payment (BPI, Equitable, Metrobank)

Premiums are in peso and inclusive of taxes.

Individual and family premiums are available in annual or semi-annual modes of payment.

Premiums may change subject to the results of medical evaluation of application form.

Premiums are inclusive of 17.7% premium tax, local tax and documentary stamp tax.



March 2007

# CONTACT US

**Head Office:**

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**Provincial Offices:**

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## SELECT MEDICAL PLAN APPLICATION FORM

**Directions:** Please answer this application form as truthfully as possible. All sections must be completed. Please use block letters.

### PERSONAL INFORMATION: Principal Applicant

FIRST NAME:

MIDDLE NAME:  LAST NAME:

MAIDEN NAME (if married):

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

BIRTHDATE:       SEX:  Male  Female WEIGHT:  lbs. HEIGHT:  feet  inches

NATIONALITY:  CIVIL STATUS:  Single  Married  Widow / Widower

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

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

**Please provide any two of the following identification numbers:**

Tax Identification No.:  Social Security System No.:

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

	Name of Beneficiary	Date of Birth	Current Age	Relationship to Applicant
<b>PERSONAL ACCIDENT BENEFICIARY:</b>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>

### CONTACT INFORMATION

<b>PRESENT ADDRESS:</b>	RESIDENCE (Number, Street, Block, Subdivision, City, Province, Country) <input style="width: 95%; height: 25px;" type="text"/> <input style="width: 95%; height: 25px;" type="text"/> BUSINESS (Number, Street, Block, Subdivision, City, Province, Country) <input style="width: 95%; height: 25px;" type="text"/> <input style="width: 95%; height: 25px;" type="text"/>	<b>MAILING ADDRESS:</b>
		<input type="checkbox"/> Residence <input type="checkbox"/> Business
<b>PERMANENT ADDRESS:</b>	(Number, Street, Block, Subdivision, City, Province, Country) <input style="width: 95%; height: 25px;" type="text"/> <input style="width: 95%; height: 25px;" type="text"/>	
<b>EMAIL ADDRESS:</b>	<input style="width: 95%; height: 25px;" type="text"/>	
<b>CONTACT NUMBERS:</b>	Residence Tel. No.: <input style="width: 200px;" type="text"/> Business Tel. No.: <input style="width: 200px;" type="text"/> Fax No.: <input style="width: 150px;" type="text"/> Mobile No.: <input style="width: 150px;" type="text"/>	

### ADDITIONAL PERSONS TO BE INSURED

Name	Date of Birth	Current Age	Relationship to Applicant
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>

**IMPORTANT:** Please fill out and provide complete details of additional persons to be insured at the back of this page.



## ADDITIONAL PERSONS TO BE INSURED

### DEPENDENT 1 (i.e. Spouse)

FIRST NAME:

MIDDLE NAME:  LAST NAME:

BIRTHDATE:    BIRTHPLACE:  SEX:  Male  Female  
day month year

NATIONALITY:  WEIGHT:  lbs. HEIGHT:  feet inches

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

NAME OF EMPLOYER:  If self-employed, type of industry:

PERSONAL ACCIDENT BENEFICIARY:	Name of Beneficiary	Date of Birth	Current Age	Relationship to Applicant
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

### DEPENDENT 2

FIRST NAME:

MIDDLE NAME:  LAST NAME:

BIRTHDATE:    BIRTHPLACE:  SEX:  Male  Female  
day month year

NATIONALITY:  WEIGHT:  lbs. HEIGHT:  feet inches

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

NAME OF EMPLOYER:  (if applicable) If self-employed, type of industry:

### DEPENDENT 3

FIRST NAME:

MIDDLE NAME:  LAST NAME:

BIRTHDATE:    BIRTHPLACE:  SEX:  Male  Female  
day month year

NATIONALITY:  WEIGHT:  lbs. HEIGHT:  feet inches

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

NAME OF EMPLOYER:  (if applicable) If self-employed, type of industry:

## MEDICAL QUESTIONNAIRE

**Directions:** Please answer the following questions for each person to be insured. For each YES response, kindly indicate the first name of the person concerned and provide complete details on the space provided on the next page.

	First Name of Applicant		First Name of Dependent 1		First Name of Dependent 2		First Name of Dependent 3	
	YES	NO	YES	NO	YES	NO	YES	NO
1. Are you covered under the Medicare Act (PhilHealth) of the Philippines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. a. Are you currently covered by any medical policy? (Please include a copy of the policy and benefit schedule.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Has any medical or life application been declined, rated or restricted?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Has any medical or life policy been cancelled, withdrawn, rated or restricted?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. respiratory or allergic condition or disorder of the eyes, ears, nose or throat ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. nervous or mental disorder, fainting, blackout, mood change, drug/alcohol addiction, seizure or fit ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. blood pressure problem, chest pain, cholesterol problem, dizziness, anemia, heart or circulatory disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. gall/kidney stone, venereal disease, or disorder of the bladder, prostate, kidney or genito-urinary tract ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. ulcer, hemorrhoid, colitis or stomach, liver or bowel disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. sciatica, back pain, joint pain or rheumatic, arthritic muscle, joint or bone disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. AIDS/AIDS Related Complex, or any indication of blood or immune system connective tissue disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. cyst, tumor or cancer ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. skin disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. hormone or glandular disorder or condition? (e.g. diabetes, thyroid problem etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. gynecological, disorder or pregnancy-related disease or complication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. injury, illness, disease or condition other than as noted above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you been a patient in a hospital, clinic or sanitarium at any given time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you been advised to have any medical test or procedure other than as noted above ? (Please provide details on next page.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been, or are you currently a smoker ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you engage in any form of sports? (Please specify on next page.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Any 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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please proceed to next page 



# Select

## PREMIUM COMPUTATION

	Principal Applicant	Dependent 1	Dependent 2	Dependent 3
First Name	_____	_____	_____	_____
<b>CORE BENEFITS (IN-PATIENT &amp; EMERGENCY) Please check box &amp; write corresponding premium based on age, plan and option chosen.</b>				
Standard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Access	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Room &amp; Board:</b>				
Ward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Semi-Private	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Private	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Subtotal Core Benefits Premium</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>OPTIONAL BENEFITS (Check box and write additional premium based on age, plan and option chosen.)</b>				
<b>Out-Patient Benefits:</b>				
Standard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Executive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Personal Accident Coverage:</b>				
P500,000 option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P1,000,000 option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Dental:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Others:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Subtotal Optional Benefits Premium</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>DEDUCTIBLE &amp; DISCOUNT OPTIONS (Check box and multiply chosen discounts accordingly.)</b>				
80 / 20 Co-Payment (25% discount for all plans, applicable to Core Benefits only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Group Discounts (Multiply by the Subtotal Premium of: Core Benefits Premium + Optional Benefits Premium [except PA &amp; APE] if any)</i>				
5% discount (7 - 15 members)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10% discount (16 or more members)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Total Amount of Applicable Discount</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>ANNUAL PREMIUM = Core Benefits Premium + Optional Benefit - Discount Chosen - Group Discount (if any)</b>				
Annual Premium (per person)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**GRAND TOTAL** \_\_\_\_\_ →

₱

**IMPORTANT NOTE:** This application form is subject to medical evaluation. Premium loading may be applied subject to the results of the medical evaluation. Select Standard and Select Plus premiums are inclusive of 17.7% premium tax, local tax and documentary stamp tax. Select Access premiums are inclusive of 12.2% local tax and E-VAT.

## 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.  
For Select Access, please make check payable to Blue Cross Health Care, Inc.)  
 Bills Payment:  BPI  Equitable PCI  Metrobank  
 Credit Card

### Credit Card Payment Authorization:

AMEX  VISA  MASTERCARD  SECURITY DINERS INT'L

Name of Cardholder:

Credit Card Account No.:

Batch Code [CVV2/CVC2 No.] (last 3 digits indicated at the back of your credit card):

Expiry Date:  Issuing Bank:

Terms of Premium Payment:  Annual (  ₱  \$ \_\_\_\_\_ )

Semi-Annual (  ₱  \$ \_\_\_\_\_ )

Until further notice (one month advance written notice is required to terminate this payment instruction),

I authorize Blue Cross Insurance, Inc. and/or Blue Cross Health Care, Inc. to charge the amount of

₱  \$  to my credit card account.

Cardholder's Signature over Printed Name	Date: <input type="text"/>
	Approval Code: <input type="text"/>

### NOTES:

## CONTACT US