

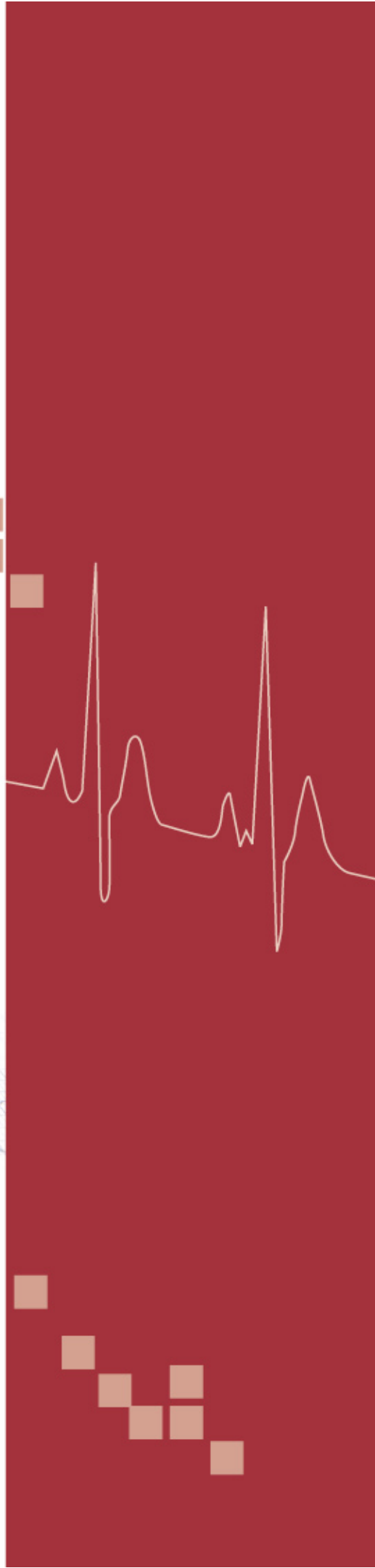


Pacific International
Insurance Company Limited

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



**MAJOR MEDICAL
PLAN**



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 International 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" 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 incorporated in Samoa by a group of investors who have built and developed various insurance businesses in Asia over the past 38 years. Many of those companies are well recognized in their respective locales, such as Blue Cross Insurance, Inc. in the Philippine.

The depth of insurance experience of "Pacific's" Board of Directors together with a group of dedicated and experienced staff have contributed to the success of the company over the eighteen years of the Company's existence.

As the years have passed and success has smiled on "Pacific", 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 attractive rates and reputation for quality service are primary reasons people choose "Pacific" for their insurance needs.



HOSPITAL & EMERGENCY 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: 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)
Organ Transplant Fees for kidney, heart, 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
AIDS Coverage will apply when signs or symptoms present for the first time after 5 years continuous coverage under the Policy and any renewal thereof, with lifetime limit of	US\$100,000
Anaesthetist's Fee	30% of eligible Surgeon's Fee
Private Nurse Fee When certified necessary by the attending physician (at home for up to 30 days immediately after hospitalization)	100%
Miscellaneous Inpatient Charges For required diagnostic laboratory fees, 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%
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
Accidental Damage to Teeth Emergency treatment for up to 7 days following accidental loss or damage caused to sound natural teeth	100%
Follow-up Care For up to 90 days of normal care immediately after hospitalization. Outpatient physician, specialist, physiotherapist and acupuncturist when certified medically necessary by the attending physician; and, for required diagnostic laboratory fees, x-rays and prescribed medicines	US\$2,500
Emergency Room Treatment & Emergency Local Ambulance Service	100%
24-Hour Emergency Assistance Services and Emergency Medical Evacuation Service	Included
Additional Travel Expenses (following Evacuation) One economy class airline ticket to return an Insured Person to the Country of Residence	

Note: "100%" herein means full reimbursement of the normal, usual and customary charge 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

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)

Travel Benefit

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

Emergency Medical Expenses - covers illness or injury including

“Emergency Evacuation” - (up to US\$25,000) with a maximum of US\$300 per day for hospital room and board 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.

Baggage & Travel Documents - covers loss and damage of baggage and personal items; and loss of travel documents up to

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

Personal Money - covers theft, burglary and robbery of cash, bank notes and travellers checks up to

Hospital Cash Income - pays US\$50 per day for each day you are hospitalized over 24 hours up to

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.

Optional Rental Car Protection - covers loss and damage occurs to a rental car result directly from fire, theft, collision or vandalism. Deductible: US\$250

(US\$2,000 option)

(US\$100,000 to US\$500,000 option)

(option)

US\$35,000

US\$500

US\$125

US\$500

US\$600

US\$650

(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, Singapore, Taiwan, Thailand and Vietnam. Countries not listed will be given individual consideration.

2: 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	530	530	664	732	802	871	939	1,008	1,150	1,222	1,295
US\$1,000,000 Benefit Option	150	150	150	150	150	150	150	150	150	150	150
Additional Room & Board Option (per US\$50 increase)	30	30	30	30	30	30	30	40	40	40	50
US\$50,000 Surgeon's Fee Option	53	53	65	71	77	83	88	93	103	109	120
ADDITIONAL BENEFIT PLANS											
Dental Plan	250	500	500	500	500	500	500	500	500	500	500
Personal Accident Plan				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 Plan	75	75	75	75	75	75	75	75	75	75	75
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: Medical premiums for age over 65 are available on request.

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, plan, option chosen and geographical loading.				
Basic 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"/> _____

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.

- | | 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 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) 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, clinic or sanitarium in the last 5 years? | <input type="checkbox"/> | <input type="checkbox"/> |

Kindly provide name and contact details of your personal physician or doctor to whom you last attended. (within past 5 years)

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/We hereby apply for a policy to be based on the above statements and declare that, to the best of my/our knowledge and belief, all answers to the foregoing questions are correctly and accurately recorded, and that they are full, complete and true.

I/We 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/us or my/our health, to give to **PACIFIC INTERNATIONAL INSURANCE COMPANY LIMITED** any such information. A photostat copy of this authorization shall be as valid as the original.

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

Name of Applicant: _____ Broker: _____
(IN BLOCK LETTERS)

PAYMENT METHOD

US Dollar (US\$) payment can be made by: 1. CHECK payable to **PACIFIC INTERNATIONAL INSURANCE COMPANY LIMITED**
2. TELEGRAPHIC TRANSFER to the bank account as noted below, or
3. CREDIT CARD using the Payment Authorization Form below.

Telegraphic Transfer Information

Beneficiary Bank: The Northern Trust International
(Paying Bank) ABA Code 026001122
Swift Code CNORUS33

Beneficiary Address: Harborside Financial Center Plaza
10 Suite 1401 3 Second Street
Jersey City, New Jersey 007311-3988

Beneficiary Account Name: Merrill Lynch, Pierce, Fenner & Smith, Inc.

Beneficiary Account Number: 106369-20010

Further Credit To: Pacific International Insurance Company Limited
Sub Account No. 137-06001

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 INTERNATIONAL 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 International Insurance Company Limited
care of our third party administrator, International Administrators Limited at the following address:
16/F, 9 Des Voeux Road West
Sheung Wan, Hong Kong, SAR

Fax: (852) 2573-2917
E-mail: inquiry@ialhk.com

GENERAL INFORMATION

Dental Benefits

A completed Oral Examination Report must be submitted with the first dental claim. All conditions requiring treatment as of the first dental visit are deemed to be pre-existing conditions.

Exclusions (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;
- ☛ Custodial Care, 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 related illness which manifests at any time within five years from the policy effective date; and
- ☛ Expenses incurred for provision of medical documentation required by the Company.

14-Day Free Look

You may return your policy within fourteen days after receipt for a full refund of the premiums paid.

FREE New Born Child Coverage

A child of an Insured Person is eligible for the same medical plan as the Insured Person 15 days after the later of the date of birth or the date of discharge on submission of application to the Company until the Insured Person's next renewal **for free**.

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 International 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 International Insurance Company Limited
c/o International Administrators Limited
16/F, 9 Des Voeux Road West
Sheung Wan, Hong Kong, SAR

Tel: (852) 2573-2278, (852) 2573-2535

Fax: (852) 2573-2917

E-mail: inquiry@ialhk.com

Website: <http://www.insurance-pacific.com>