Emergency Medical
Travel Insurance

Medical Underwriting Plan

Form 1 - Application and Medical Questionnaire (to be completed by the physician)

For Broker/Sales Agent use only:

Company Name: Simpson Group Insurance Services Contact Person: Jeff Simpson

Tel. Number: (403) 281-4403 Fax Number: (403) 281-4503 E-mail: info@simpson-group.com

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Part A CLIENT INFORMATION

Name: Date of Birth (d/m/y): / /

Address:

Tel. Number: Fax Number: E-mail:

Travel Dates Departure (d/m/y): / / Return (d/m/y): / / **Trip Duration:** days

Exact Destination City: State: Country:

IMPORTANT NOTICE

Important Notice About Your Personal Information: By submitting this application you agree that Royal & Sun Alliance Insurance Company of Canada ("we", "us") may collect, use and disclose your Personal Information (including to and from your broker, our affiliates and service providers and organizations that may have referred you to us, and professional associations of which you may be a member) for purposes of quoting a premium, policy administration, improving customer experience, administering referral arrangements, and for other lawful purposes described in our Protecting Customer Privacy document. For a copy of this document please see www.rsatravelinsurance.com.

Part B MESSAGE TO THE PHYSICIAN

Filling out this questionnaire* will assist your patient to obtain the proper emergency medical insurance while he or she is travelling. Proper coverage will safeguard your patient's financial security.

Although your patient does not qualify for our regular insurance plan, the answers you provide regarding your patient's health status may enable us to offer a modified travel insurance plan.

Please include any additional relevant information that may help in our assessment. Do not include any results of genetic testing.

If you feel your patient should not be travelling, please discuss this matter with him or her and advise us in Part D - Comments. We appreciate your cooperation.

***IMPORTANT: Charges levied for the completion of this document remain your patient's responsibility.**

Part C MEDICAL QUESTIONNAIRE (Please type or print clearly)

List all diagnoses and medical and/or surgical conditions	Date of initial presentation	List all current medications	Date of initial prescription	Medication changes (including dosage and date) in the last 12 months	
				Medication	Dates (d/m/y)

1. Has your patient taken **Lasix** or **other diuretic in the last 5 years?**

☐ yes ☐ no If yes, please provide date & dosage: _____

If so, for what condition? ☐ CHF ☐ HTN ☐ Peripheral Edema ☐ Other (please specify): _____

2. Does your patient take an **ACE-inhibitor?** ☐ yes ☐ no

If so, for what condition? ☐ CHF ☐ HTN ☐ Other (please specify): _____

3. List any other therapy required during the past **3 years** (e.g. home oxygen, chemotherapy, radiation therapy, etc.).

Therapy: _____ Date or period of treatment (d/m/y): / /

Therapy: _____ Date or period of treatment (d/m/y): / /

Therapy: _____ Date or period of treatment (d/m/y): / /

4. List all hospitalizations during the past **3 years**.

Date of hospitalization (d/m/y): / / Diagnosis: _____

Date of hospitalization (d/m/y): / / Diagnosis: _____

Date of hospitalization (d/m/y): / / Diagnosis: _____

5. List all major tests and investigations during the past **2 years** (e.g. cardiac stress test, cardiac catheterization, scans). **Please include a copy of the test results.**
List other recent significant tests (e.g. Hgb for anemia, creatinine for renal insufficiency, LFTs for cirrhosis, etc.).

Test/investigation: _____ Date (d/m/y): / / Results: _____

Test/investigation: _____ Date (d/m/y): / / Results: _____

Test/investigation: _____ Date (d/m/y): / / Results: _____

Ejection fraction (if known): % Date (d/m/y): / / **Smoking status:** ☐ yes ☐ no

6. Is the patient awaiting investigations, surgery or any other treatment?

☐ yes ☐ no If so, please specify the **type** and the **date** (d/m/y): _____

7. Has your patient ever undergone a **Coronary Artery Bypass Graft?** ☐ yes ☐ no Date (d/m/y): _____/_____/_____

Angioplasty? ☐ yes ☐ no Date (d/m/y): _____/_____/_____

Stenting? ☐ yes ☐ no Date (d/m/y): _____/_____/_____

8. Has the patient ever had a functional **cardiac classification** for **Angina**? ☐ yes ☐ no

If so, what is the patient's **CURRENT class** of **Angina**? ☐ I ☐ II ☐ III ☐ IV Date of last episode (d/m/y): _____/_____/_____

9. Has the patient ever been diagnosed or treated for **Congestive Heart Failure**? ☐ yes ☐ no

If so, what is the patient's **CURRENT class** of **Congestive Heart Failure**? ☐ I ☐ II ☐ III ☐ IV Date of last episode (d/m/y): _____/_____/_____

Part D COMMENTS

Part E PHYSICIAN INFORMATION

How long has the applicant been your patient (d/m/y)? / / Are you this patient's family physician, specialist or other?

Physician's Name: _____

Address: _____

Physician's License Number: _____ Tel. Number: _____ Fax Number: _____

PHYSICIAN'S SIGNATURE: _____ **DATE (d/m/y):** _____/_____/_____

This form must be returned to: **RSA c/o Medical Underwriting, 1910 King Ouest, Suite 200, Sherbrooke, Quebec J1J 2E2**
Tel.: 1-800-680-3837 Fax: 819-566-8067