Allianz
Global Assistance

APPLICANT INFORMATION

First Name	Last Name	Birth Date (mm/dd/yyyy)	Sex
			☐M ☐F
			☐M ☐F
			☐M ☐F
			☐M ☐F
			☐M ☐F

Address (in Canada)

City / Prov. | Postal Code

Telephone Number | Email Address

Beneficiary Name & Relationship

APPLICATION DETAILS

Departure Point _____ Departure Date _____

Destination _____ Effective Date _____

# of Days _____ Expiry Date _____

COVERAGE DETAILS

Check all that apply:	Premium Rate	# of Persons	# of Days	Total Premium
Single Trip Emergency Hospital Medical ☐ U.S.A. Plan ☐ Non-U.S.A. Plan ☐ Canada Only	$			$
Youth Plan ☐ U.S.A. Plan ☐ Non-U.S.A. Plan	$			$
Multi-Trip Annual ☐ 4 ☐ 8 ☐ 15 ☐ 35 ☐ 60 ☐ 125 ☐Basic ☐Select ☐Option 1 ☐Option 2	$			$
Trip Cancellation and Interruption ☐ Basic ☐ Select Sum Insured prior to Departure $ _____ Sum Insured after Departure: $25,000	$			$
All-Inclusive Package ☐ USA Package ☐ Non-USA Package Sum Insured prior to Departure $ _____ Sum Insured after Departure: $25,000	$			$
Optional Plans ☐ Baggage ☐ $1,000 ☐ $1,500 ☐ Accidental Death & Dismemberment ☐ $25,000 ☐ $100,000 ☐ $250,000 ☐ Flight Accident ☐ $200,000 ☐ $500,000 ☐ Trip Interruption ☐ $800 ☐ $1,500 ☐ $2,000	$			$
Minimum premium levels apply.			Total Premium Due	$

DEDUCTIBLES - Applies to Single Trip, Youth Plan and Multi-Trip Annual plans

☐ $0 (+10%) ☐ $250 CAD (auto)

DECLARATION

To be eligible for coverage you must, as of the date you apply for coverage and the effective date:

a) be at least 15 days old and no more than 89 years old; and

b) be insured for benefits under a Canadian government health insurance plan during the entire period of coverage; and

c) not have been diagnosed with a terminal illness; or

d) not have been diagnosed with stage 3 or 4 cancer; or have received treatment for any cancer (other than basal or squamous cell cancer or breast cancer treated only with hormone therapy) in the last 3 months; or

e) not require assistance with activities of daily living as the result of a medical condition or state of health

_____ _____

Signature of Insured (or person acting on behalf of insured) Date (mm/dd/yyyy)

PAYMENT

☐ Visa ☐ Master Card ☐ Amex ☐ Cheque ☐ Cash

Card Number __/__/__/__/ __/__/__/__/ __/__/__/__/ __/__/__/__/ Expiry Date __/__

Name of Card Holder _____

Signature of Card Holder _____

Submit application to:
Simpson Group Insurance Services Inc.

Fax: (403) 281 4503

For more information, please call:
Simpson Group Insurance Services Inc.
Phone: (403) 281 4403
Toll free: 1 800 263 0752
E-mail: info@simpson-group.com