.:Medi-Select Advantage®
Travel Insurance

# Application

Age 55 or over

**Effective August 2016**

RSA

| For Broker / Sales Agent Use Only | | 10 01 APM ECA 0816 000 |
|---|---|---|
| **Applicant 1** Policy Number: | **Applicant 2** Policy Number: | Date Issued (D/M/Y): |

**This Application must be completed prior to the effective date. ONLY YOU can complete and sign the Medical Questionnaire, not your spouse, broker or sales agent. Should you need to make a correction to your answers pertaining to the medical questions in this Application, please call your broker or sales agent for instructions.**

## A – Personal Information

**Applicant 1**

First Name _____ Last Name _____ Date of Birth (D/M/Y) _____/_____/_____

☐ Male ☐ Female

**Applicant 2**

First Name _____ Last Name _____ Date of Birth (D/M/Y) _____/_____/_____

☐ Male ☐ Female

**Home Address**

Street _____ City _____ Province _____

Postal Code _____ Telephone _____ E-mail _____

**Destination Address**

Street _____ City _____ Province / State / Country _____

Postal / Zip Code _____ Telephone _____ E-mail (if different from home e-mail) _____

**Emergency Contact**

First Name _____ Last Name _____ Telephone _____

## B – Definitions

Throughout the Medical Questionnaire, defined words are written in italics. Please refer to them as they are important definitions.

1. **Terminal illness**: means that you have a medical condition that is cause for a physician to estimate that you have less than 6 months to live or for which palliative care has been received.
2. **Metastatic cancer**: means a cancer that has spread from its original site to one or more other area(s) of the body.
3. **Treated**: means that you have been hospitalized, have been prescribed medication (including prescribed as needed), have taken or are currently taking medication, or have undergone a medical or surgical procedure. Note that aspirin/entrophen is not considered treatment.
4. **Stable**: means any medical condition (other than a *minor ailment*) for which all the following statements are true:
   a) There has been no new diagnosis, treatment or prescribed medication.
   b) There has been no change in treatment or change in medication, including the amount of medication to be taken, how often it is taken, the type of medication or change in treatment frequency or type.
   Exceptions: the routine adjustment of Coumadin, Warfarin, insulin or oral medication to control diabetes (as long as they are not newly prescribed or stopped) and a change from a brand name medication to a generic brand medication (provided that the dosage is not modified.)
   c) There have been no new symptoms, more frequent symptoms or more severe symptoms.
   d) There have been no test results showing deterioration.
   e) There has been no hospitalization or referral to a specialist (made or recommended) and you are not awaiting results of further investigations for that medical condition.
5. **Minor ailment**: means any sickness or injury which does not require: the use of medication for a period of greater than 15 days; more than one follow up visit to a physician, hospitalization, surgical intervention or referral to a specialist; and which ends at least 30 consecutive days prior to the departure date of each trip. However, a chronic condition or any complication of a chronic condition is not considered a minor ailment.
6. **Regular check-up**: means any standard or customary medical examination unrelated to any specific medical condition and which is carried out for the purpose of screening, health monitoring or preventive care and may include routine medical tests and investigations.

## IMPORTANT NOTICE

**Important Notice About Your Health Changes: If your health changes or does not remain *stable*** between the date you complete and submit this Medical Questionnaire and your effective date, **you must review the medical questions with your broker or sales agent**. If you are no longer eligible, or no longer qualify for the insurance plan you purchased and you fail to contact your broker or sales agent, your claim will be denied, the Insurer will void your policy, and the premium you paid will be refunded. This means no benefits will be covered and you will be responsible for all expenses relating to your sickness or injury, including repatriation costs. If you are purchasing a Multi-Trip Annual Plan and your health changes or does not remain *stable* after the effective date, your medical condition may not be covered (see Pre-Existing Medical Condition Exclusions).

**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.

**I understand that in the event of a claim, the answers I provide herein will be reviewed for accuracy by the Insurer. If they are inaccurate in any way, my claim will be denied.**

## C – Are you eligible?

**This insurance is only available if you are a Canadian resident covered by the Government Health Insurance Plan of your Canadian province or territory of residence for the entire duration of your trip.**

| | Applicant 1 | Applicant 2 |
|---|---|---|
| 1. Coverage is NOT AVAILABLE to any individual who:<br>• is travelling against the advice of a physician;<br>• has been diagnosed with a ***Terminal illness*** or ***Metastatic cancer***;<br>• has a **Kidney disease** requiring dialysis; or<br>• has been prescribed or used **home oxygen** in the 12 months prior to their application date.<br>**Please confirm your eligibility to apply for this insurance.** | ☐ **Eligible**<br>☐ **Not Eligible** | ☐ **Eligible**<br>☐ **Not Eligible** |

**If you are eligible and are applying for the Canada Plan, 55-79 Vacation Plan, Single Trip Non-Medical Plan or 40-Day PSHCP Plan, you may proceed directly to Section I. If you are eligible and applying for any other plan, please continue to section D.**

## D – Do you require customized Medical Underwriting?

| | Applicant 1 | Applicant 2 |
|---|---|---|
| 2. Have you had **Heart bypass surgery** or **Heart angioplasty** (including stent placement) more than 12 years ago? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 3. Have you ever had a **Bone marrow transplant** or an **Organ transplant** (excluding corneal transplant)? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 4. Do you have a surgically unrepaired **Aneurysm** of 4.0 cm or more? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 5. In the past 5 years, have you been diagnosed with or *treated* for **Congestive heart failure** or **Cardiomyopathy** or are you currently taking **Lasix**, **Furosemide** or a **water pill** (excluding a water pill taken for high blood pressure only)? | ☐ Yes ☐ No | ☐ Yes ☐ No |

**If you have answered YES to ANY question in Section D, please contact your broker or sales agent. Otherwise, continue to Section E.**

## E – Do you use tobacco products?

| | Applicant 1 | Applicant 2 |
|---|---|---|
| 6. In the past 5 years, have you smoked or used any tobacco products? | ☐ Yes ☐ No | ☐ Yes ☐ No |

**If you have answered YES to Question 6, a 20% surcharge will apply to your premium. Please continue to Section F.**

## F – Which plan do you qualify for?

### PART 1 – ADVANTAGE OR STANDARD?

| | Applicant 1 | Applicant 2 |
|---|---|---|
| 7. In the past 10 years, have you been diagnosed with or *treated* for a **Heart condition** (including stent placement, pacemaker and/or defibrillator)? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 8. In the past 5 years, have you been diagnosed with or *treated* for: | | |
| a) **Diabetes** or **Glucose intolerance** (pre-diabetes)? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b) **Stroke** or **Mini-stroke** (CVA/TIA)? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| c) **Peripheral Vascular Disease** (PVD), **Carotid Artery Stenosis** or any narrowed or blocked artery, excluding coronary artery disease? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| d) **Lung condition** (such as any prescription for puffers/inhalers), excluding lung cancer or a *minor ailment*? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| e) **Dementia** or **Alzheimer's disease**? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| f) **Cancer** (excluding basal or squamous cell skin cancer)? | ☐ Yes ☐ No | ☐ Yes ☐ No |



*Section F - Continued on next page*

## F – Which plan do you qualify for? (Continued)

| | Applicant 1 | Applicant 2 |
|---|---|---|
| 9. In the past 2 years, have you been diagnosed with or *treated* for any of the following:<br>• **Chronic bowel disease** (such as but not limited to Crohn's disease or Ulcerative colitis)?<br>• **Gastrointestinal bleeding, Bowel obstruction** or have had **Bowel surgery**?<br>• **Gallbladder disease** (including stones)? Not applicable if your gallbladder has been removed.<br>• **Kidney disease** (including stones), **Liver disease** or **Pancreatitis?** | ☐ Yes ☐ No | ☐ Yes ☐ No |

**If you have answered NO to ALL questions in Part 1, please continue to Part 2.**
**If you have answered YES to ONLY 1 question in Part 1, you qualify for Advantage. If you have answered YES to 2 OR MORE questions in Part 1, you qualify for Standard. Please continue to Section G.**

### PART 2 – SUPREME OR ELITE?

| | | |
|---|---|---|
| 10. Has it been more than 24 months since your last ***regular check-up*** with a physician? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 11. In the past 12 months, have you been diagnosed with or *treated* for: | | |
| a) **High blood pressure**? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b) **High cholesterol**? | ☐ Yes ☐ No | ☐ Yes ☐ No |

**If you have answered NO to ALL questions in Part 2, you qualify for Supreme. If you have answered YES to ANY question in Part 2, you qualify for Elite. Please continue to Section G.**

## G – Qualification Table

PLEASE INDICATE THE COVERAGE YOU QUALIFY FOR and read the Pre-Existing Medical Condition Exclusions.

| You Qualify for | Pre-Existing Period | Applicant 1 | Applicant 2 |
|---|---|---|---|
| Supreme | 90 days | ☐ | ☐ |
| Elite | 90 days | ☐ | ☐ |
| Advantage | 365 days | ☐ | ☐ |
| Standard | 365 days | ☐ | ☐ |

### PRE-EXISTING MEDICAL CONDITION EXCLUSIONS

**This insurance does not cover losses or expenses caused directly or indirectly, in whole or in part, by:**

1. Any sickness, injury or medical condition (other than a *minor ailment*) that was not *stable* at any time during the applicable Pre-Existing Period prior to each departure date.
2. Your heart condition, if **any** heart condition was not *stable* at any time during the applicable Pre-Existing Period prior to each departure date.
3. Your lung condition, if:
   a) **any** lung condition was not *stable*; or
   b) you have been *treated* with home oxygen or taken oral steroids (e.g., prednisone) for **any** lung condition;

   at any time during the applicable Pre-Existing Period prior to each departure date.

## H – Agreement, Understanding and Authorization

You must read and understand the importance of each of the following statements and **sign below**.

- **A PRE-EXISTING MEDICAL CONDITION EXCLUSION** may apply to medical conditions and/or symptoms that existed prior to my trip. I understand that any medical condition I have, including those disclosed in **SECTION F**, will be subject to the Pre-Existing Medical Condition Exclusions. I will refer to my policy for the full Pre-Existing Medical Condition Exclusion clause.
- Where I was unsure of my medical history as it relates to the medical questions, I have verified it with my physician. I personally provided the answers on this Medical Questionnaire and I warrant that all information disclosed herein is correct and complete. In the event of a claim, I fully understand that the Insurer will review my prior medical history and these answers and, if any of my answers are incorrect or incomplete, the Insurer will void my policy and my claim will be refused, regardless of whether the incorrect or incomplete answer to any question is related to the cause of my claim or would have rendered me ineligible or resulted solely in a higher applicable premium. I understand that the answers on my Medical Questionnaire are relevant to the risk and constitute the basis of my insurance.
- I understand the necessity of calling to obtain approval before seeking medical attention in case of a claim or medical emergency. The toll free telephone number can be found on my wallet card and in my insurance policy.
- Medical Authorization in Case of a Claim – I understand that the insurer may investigate my claim. By signing this Medical Questionnaire, I also hereby direct and authorize any physician, health care practitioner, hospital or other medical care facility, pharmacy, the Ministry of Health or any other person who has attended and examined me or who has knowledge or records of me or my health, to furnish to Royal & Sun Alliance Insurance Company of Canada and to its authorized administrator, Global Excel Management Inc., any or all information with respect to my sickness, injury, medical history, consultations, medicines or treatment and copies of all hospital or medical records for the purpose of investigating my claim.
- I understand that some exclusions may apply and affect my coverage. I will read my insurance policy for additional details.

| Applicant 1 Signature | Date of Signature (D/M/Y) | Applicant 2 Signature | Date of Signature (D/M/Y) |
|---|---|---|---|
| | | | |

# I – Trip Information

Check the applicable Plan and Qualification you are applying for.

## Applicant 1

**PLANS**

**Multi-Trip Annual** ☐ 4-Day ☐ 9-Day ☐ 16-Day ☐ 30-Day

**All-Inclusive Multi-Trip Annual** ☐ 4-Day ☐ 9-Day ☐ 16-Day ☐ 30-Day

☐ **40-Day PSHCP Supplemental**

Effective Date (D/M/Y): ____/____/____

☐ **Single Trip Daily Plan** ☐ **55-79 Vacation Plan**

☐ **Canada Plan** ☐ **Single Trip Non-Medical Plan***

Departure Date (D/M/Y): ____/____/____ * Trip Value: $ _____

Expiry Date (D/M/Y): ____/____/____ Effective Date (D/M/Y): ____/____/____

**TOP UPS**

Departure Date (D/M/Y): ___/___/___ Number of Pre-insured days: _____

Top Up Effective Date** (D/M/Y): ___/___/___ Expiry/Return Date (D/M/Y): ___/___/___

Name of the other Insurer: _____

** **The Top Up Effective Date will be the day after your existing coverage terminates.**

**QUALIFICATION** (For Medical Questionnaire Applicants only)

☐ **Supreme** ☐ **Elite** ☐ **Advantage** ☐ **Standard**

**DEDUCTIBLE OPTIONS** (For Medical Questionnaire Applicants only)

☐ $0 (+10%) ☐ **$250 US (0%)** ☐ $500 US (-5%)

☐ $1,000 US (-10%) ☐ $5,000 US (-30%) ☐ $10,000 US (-45%)

**TOBACCO USER** (For Medical Questionnaire Applicants only)

During the 5 years prior to your application, have you smoked or used any tobacco products? ☐ Yes ☐ No

## Applicant 2

**PLANS**

**Multi-Trip Annual** ☐ 4-Day ☐ 9-Day ☐ 16-Day ☐ 30-Day

**All-Inclusive Multi-Trip Annual** ☐ 4-Day ☐ 9-Day ☐ 16-Day ☐ 30-Day

☐ **40-Day PSHCP Supplemental**

Effective Date (D/M/Y): ____/____/____

☐ **Single Trip Daily Plan** ☐ **55-79 Vacation Plan**

☐ **Canada Plan** ☐ **Single Trip Non-Medical Plan***

Departure Date (D/M/Y): ____/____/____ * Trip Value: $ _____

Expiry Date (D/M/Y): ____/____/____ Effective Date (D/M/Y): ____/____/____

**TOP UPS**

Departure Date (D/M/Y): ___/___/___ Number of Pre-insured days: _____

Top Up Effective Date** (D/M/Y): ___/___/___ Expiry/Return Date (D/M/Y): ___/___/___

Name of the other Insurer: _____

** **The Top Up Effective Date will be the day after your existing coverage terminates.**

**QUALIFICATION** (For Medical Questionnaire Applicants only)

☐ **Supreme** ☐ **Elite** ☐ **Advantage** ☐ **Standard**

**DEDUCTIBLE OPTIONS** (For Medical Questionnaire Applicants only)

☐ $0 (+10%) ☐ **$250 US (0%)** ☐ $500 US (-5%)

☐ $1,000 US (-10%) ☐ $5,000 US (-30%) ☐ $10,000 US (-45%)

**TOBACCO USER** (For Medical Questionnaire Applicants only)

During the 5 years prior to your application, have you smoked or used any tobacco products? ☐ Yes ☐ No

# J – Premium and Payment

For manual applications, please complete the Premium Calculation page to determine each Applicant's total premium. For rates to top up the All-Inclusive Multi-Trip Annual Plan, contact your broker or sales agent.

If you are applying for the Canada Plan, 55-79 Vacation Plan, Single Trip Non-Medical Plan or 40-Day PSHCP Plan, complete the Premium Calculation – Plans **without** Medical Questionnaire page.

If you are applying for all other plans, complete the Premium Calculation – Plans **with** Medical Questionnaire page.

**Total Premium** $ Applicant 1 + $ Applicant 2 = $ TOTAL

**Method of Payment** ☐ Visa ☐ MasterCard ☐ AMEX ☐ Cheque made payable to the broker or sales agent indicated on the front of this application

**Credit Card Information**

Card Number | Expiry Date (M/Y)

Name of Cardholder | Signature of Cardholder | Date Signed (D/M/Y)