Emergency Medical
Travel Insurance

Medical Underwriting plan

Form 1 - Application and medical questionnaire (to be completed by the physician)

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Company Name: Simpson Group Insurance Services Inc. Email: info@simpson-group.com

Phone Number: (403) 281-4403 Toll Free Number: 1(800) 263-0752 Fax: (403) 281-4503

Part A CLIENT INFORMATION

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

Tel. Number: Fax Number: E-mail:

Address:

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

Exact Destination City: State: Country:

Note: The masculine gender is used in this document for the sole purpose of lightening the text.

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

In taking time to fill out this questionnaire, you are helping your patient to obtain the proper emergency health insurance while he is travelling. Proper coverage will safeguard your patient's financial security.*

The answers you provide regarding your patient's health status will help us to determine his eligibility to purchase travel insurance. Although he does not qualify for our regular insurance plan, we may be able to offer the applicant a modified travel insurance program.

Please include any relevant information you feel may help us assess this patient's medical stability. If you feel your patient's condition is too unstable for him to travel this year, please discuss this matter with him and advise us in Part D - Comments. We appreciate your cooperation.

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

Part C 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

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, chemo, radiation therapy, etc.).

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

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

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

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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:

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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:

Prof. No.: Telephone: Fax:

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