Quest Travel Insurance

Applicant 1:

Name _____ Date of Birth _____ Male ☐ Female ☐ Age _____
DD/MM/YYYY

Applicant 2:

Name _____ Date of Birth _____ Male ☐ Female ☐ Age _____
DD/MM/YYYY

Address _____ City _____ Prov _____ Postal Code _____

Phone Number _____ Email Address _____

TRIP INFORMATION

☐ **Single Trip** Effective Date _____ Expiry Date _____ # of Days _____

☐ **Multi Trip Annual** ☐ 9 day ☐ 16 day ☐ 30 day ☐ 60 day Effective Date _____

Are you presently in your home province? ☐ Yes ☐ No

☐ **Top Up Policy**

Number of Days covered under other insurance _____

Name of Insurance Plan _____

Departure Date _____ Expiry Date _____

☐ **Trip Cancellation/Interruption**

Sum Insured Prior to Departure $_____

Sum Insured After Departure (check one) ☐ $800 ☐ $1,500 ☐ $10,000 ☐ $25,000

Date Trip was booked: _____

ELIGIBILITY QUESTIONNAIRE

Please review the Eligibility questions to see if you are eligible. To be eligible to purchase this insurance, you must be 55-89 years of age and must answer **NO to questions 1 to 9.**

1. In the 36 months prior to the application have you been diagnosed with, treated or ordered by a physician to take medication for ***three (3) or more*** of the following medical conditions?

- ˚ Heart disease/condition
- ˚ Liver disease/condition
- ˚ Lung disease/condition (excluding asthma not requiring prednisone)
- ˚ Diabetes (requiring medication)
- ˚ Stroke or mini-stroke (TIA or transient ischemic attack)

2. In the 12 months prior to application, have you been diagnosed with, treated or been ordered by a physician to take medication for peripheral vascular disease (blocked leg arteries), congestive heart failure, chronic obstructive pulmonary disease (COPD, emphysema)?

3. In the 12 months prior to application, have you used or been prescribed home oxygen?

4. Do you have a terminal condition or metastatic cancer?

5. Did you have heart bypass surgery more than 10 years before application? (Answer "no" to this question if you have had additonal bypass surgery and/or placement of a stent less than 10 years prior to application)

6. Have you had an organ transplant (excluding cornea or skin graft)?

7. Do you have a kidney disease requiring kidney dialysis?

8. Do you have an aneurysm larger than four (4) centimetres, measured in either length or diameter?

9. In the 6 months prior to application have you had a stroke or mini-stroke (TIA or transient ischemic attack)?

If you answered **YES** to any of the eligibility questions listed above, you are not eligible to purchase this insurance.

If you answered **NO** to all the eligibility questions above you must **initial below** before proceeding to the Medical Questionnaire.

My electronic initial on this application has the same effect as if I signed it in ink.

Initials Required: ***Applicant 1*** _____ ***Application 2*** _____

Name of Applicant 1: _____ **Name of Applicant 2:** _____

Please complete the Medical Questionnaire. If you are unsure about how to answer any of these questions please consult your physician.

MEDICAL QUESTIONNAIRE		
	Applicant 1	***Applicant 2***
10. In the 5 years prior to application have you been diagnosed with, treated or ordered by a physician to take medication or been hospitalized for any of the following:		
Heart attack, aneurysm, angioplasty, atrial fibrillation, artery bypass surgery, cardiac surgery, angina, irregular heartbeat, pacemaker, thrombosis, phlebitis, pulmonary oedema	☐ YES ☐ NO	☐ YES ☐ NO
Chronic asthma, chronic bronchitis, pneumonia	☐ YES ☐ NO	☐ YES ☐ NO
Diabetes (requiring medication)	☐ YES ☐ NO	☐ YES ☐ NO
Stroke or mini-stroke (TIA or transient ischemic attack)	☐ YES ☐ NO	☐ YES ☐ NO
Carotid artery stenosis (blocked or clogged arteries in the legs or neck)	☐ YES ☐ NO	☐ YES ☐ NO
Liver disease/condition	☐ YES ☐ NO	☐ YES ☐ NO
Cancer (excluding basal cell skin cancer)	☐ YES ☐ NO	☐ YES ☐ NO
Kidney disease that required dialysis, now no longer on dialysis	☐ YES ☐ NO	☐ YES ☐ NO

If you answered **YES** to any condition in question 10, you qualify for the **Bronze** plan. Please proceed to question 16.
If you answered **NO**, proceed to question 11.

11. In the 24 months prior to application, how many of the following medical conditions have you been diagnosed with, treated for or ordered by a physician to take medication for?		
Kidney disease	☐ YES ☐ NO	☐ YES ☐ NO
Gastrointestinal bleeding	☐ YES ☐ NO	☐ YES ☐ NO
Alzheimer's disease/dementia	☐ YES ☐ NO	☐ YES ☐ NO
Pancreatitis	☐ YES ☐ NO	☐ YES ☐ NO
Chronic bowel disease	☐ YES ☐ NO	☐ YES ☐ NO
Bowel obstruction	☐ YES ☐ NO	☐ YES ☐ NO

If you have **TWO OR MORE** of the conditions in question 11, you qualify for the **Bronze** plan. Proceed to question 16.
If you have **ONE** of the conditions in question 11, you qualify for the **Silver** plan. Proceed to question 16.
If you have **NONE** of the conditions in question 11, proceed to question 12.

12. In the 12 months prior to application, have you been diagnosed with or undergone a change in medical treatment (including an alteration in medication dosage or usage) for high blood pressure ***AND*** had any of the following conditions?		
High cholesterol	☐ YES ☐ NO	☐ YES ☐ NO
Diabetes (not requiring medication)	☐ YES ☐ NO	☐ YES ☐ NO
Gallbladder disease	☐ YES ☐ NO	☐ YES ☐ NO
Osteoporosis	☐ YES ☐ NO	☐ YES ☐ NO
Arthritis	☐ YES ☐ NO	☐ YES ☐ NO

If you answered **YES** to high blood pressure AND any other conditions in question 12, you qualify for the **Silver** plan. Proceed to question 16.
If you answered **NO** to question 12, proceed to question 13.

13. Have you ever been treated for a heart disease/condition (excluding congenital heart disease)?	☐ YES ☐ NO	☐ YES ☐ NO
14. Was your last regular check-up with a physician more than 24 months ago?	☐ YES ☐ NO	☐ YES ☐ NO
15. Have you had a fall that you reported to a physician in the last 6 months?	☐ YES ☐ NO	☐ YES ☐ NO

If you answered **YES** to question 13, 14 or 15 you qualify for the **Silver** plan. Proceed to question 16.
If you answered **NO** to questions 13, 14 and 15 you qualify for the **Gold** plan. Proceed to question 16.

MEDICAL QUESTIONNAIRE continued		
	Applicant 1	***Applicant 2***
16. In the 12 months prior to application, have you smoked tobacco products?	☐ YES ☐ NO	☐ YES ☐ NO

If you answered **YES** to question 16 and you qualify for:

Bronze plan, add **30%** to the base premium
Silver plan, add **15%** to the base premium
Gold plan, add **10%** to the base premium

Please read and sign:

If you have any doubt about your medical condition(s) as it relates to the previous questions, you should consult your physician for advice before completing this medical health questionnaire.

If you qualify for the coverage selected but fail to answer truthfully and accurately any question asked at the time of the application, any claim will be subject to an extra deductible of $15,000 USD in addition to any other applicable deductible amount. No future coverage will be provided under this Policy unless you pay any additional premium reflecting true and accurate answers to those questions.

I understand that the medical conditions disclosed on this application may not be covered. Details related to pre-existing conditions coverage are set out in the Policy booklet.

I/we confirm that I/we have answered this Medical Health Questionnaire truthfully and accurately as it relates to my/our health conditions.

My electronic signature on this application has the same effect as if I signed it in ink.

_____ _____ _____

SIGNATURE *Applicant 1* **SIGNATURE *Applicant 2*** **Date**

OPTIONAL ADD-ONS (Please check if required)

Guaranteed Stability Option
Surcharge 40% *Applicant 1* ☐ *Applicant 2* ☐

Future Stability Option
Surcharge 10% *Applicant 1* ☐ *Applicant 2* ☐

Deductible	Discount	
$0 USD	0%	☐
$300 USD	-10%	☐
$500 USD	-15%	☐
$1,000 USD	-20%	☐
$5,000 USD	-35%	☐
$10,000 USD	-40%	☐
$50,000 USD	-55%	☐
$100,000 USD	-70%	☐

PREMIUM

Applicant 1: $_____ Applicant 2: $_____ TOTAL: $_____

Method of Payment

☐ Visa ☐ Master Card ☐ Amex ☐ Cash/Cheque

Card Number __ / __ / __ / __ __ / __ / __ / __ __ / __ / __ / __ __ / __ / __ / __ Expiry Date __ /__ CVV _____

Name of Card Holder _____

Signature of Card Holder _____

SG

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