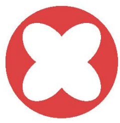

Allianz Global Assistance

APPLICANT INFORMATION

First Name	Last Name	Birth Date (mm/dd/yyyy)	Sex
			☐ 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 or Canada				
Multi-Trip Annual ☐ 4 ☐ 8 ☐ 15 ☐ 35 ☐ 60 ☐ 125 ***Are you presently in your home province:*** ☐ Yes ☐ No				
Trip Cancellation and Interruption ☐ Basic ☐ Select Sum Insured prior to Departure $ _____________ Sum Insured after Departure: $25,000				
Optional Plans Accidental Death & Dismemberment $25,000 $100,000 $250,000 Flight Accident $200,000 ☐ $500,000 Trip Interruption $800 $1,500 $2,000				
			Total Premium Due	$

DEDUCTIBLES Applies to Single Trip and Multi-Trip Annual *in Canadian dollar*

☐ $0 (+10%)	☐ $250	☐ $1,250 (-10%)	☐ $6,000 (-30%)
☐ $12,000 (-40%)	☐ $30,000 (-45%)	☐ $100,000 (-80%)	

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
f) not have been prescribed or used home oxygen for a lung/respiratory condition during the previous 12 months; or
g) not have your most recent heart surgery more than 12 years ago or less than 6 months ago; or
h) not have a diagnosed unrepaired aneurysm of 4 centimetres or greater, measured in either length or diameter; or
i) not have received or are awaiting a bone marrow or major organ transplant; or
j) not have been diagnosed with or received treatment for a kidney disease requiring dialysis; or
k) not have been diagnosed with an auto-immune disorder; or
l) not have ever been diagnosed with congestive heart failure

____ ______________________
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 __/__ CVV _________
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