

21st CENTURY VISITORS TO CANADA INSURANCE INFORMATION FORM

Return this form to:

Ray Battiston Insurance Broker
 151 Osprey Crescent
 Callandar, ON P0H 1H0 Canada
 Open – Monday to Friday 9-5pm EST
 www.IceColdNorth.com

STEP 1. PERSONAL INFORMATION

Last Name of Applicant(s)		First Name		Date of Birth (mm/dd/yy)
1.				
2.				
3.				
4.				
Country of Origin:		Name of Sponsor:		
Address in Canada:				
City:	Prov:	Postal Code:	Phone:	

Check one only New Immigrant Returning Canadian Visitor Work/Student Visa Other: _____
 Check one only relating to current visit: No prior policy issued Most recent prior 21st Century Travel Insurance Policy # _____

STEP 2. ELIGIBILITY - Confirm all applicants are eligible for this policy. Applicants are not eligible if they:

- a) have been advised by a physician not to travel and/or;
 b) have been diagnosed with a terminal illness with less than two (2) years to live; and/or
 c) have a kidney condition requiring dialysis; and/or
 d) have used home oxygen during the 12 months prior to the date of application.

STEP 3. COVERAGE DATES

Application Date mm/dd/yy	Time of Issue a.m. / p.m.	Arrival Date mm/dd/yy
Effective Date mm/dd/yy	Expiry Date mm/dd/yy	No. of Days (Including Effective & Expiry Dates-Maximum 365 days)

STEP 4. MEDICAL DECLARATION (Skip if under age 70 on Effective Date)

Check YES or NO

Answer the following questions to determine eligibility.	Applicant 1	Applicant 2
1. Within the past 24 months have you had any of the following: a) a heart attack or congestive heart failure; b) an organ or bone marrow transplant; c) diagnosis or monitoring of, or treatment for a heart valve disorder; or d) diagnosis or monitoring of, or treatment for a lung condition (excluding asthma)?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
2. Within the past 12 months have you been diagnosed with, been hospitalized for, taken or been prescribed medication for stroke, mini-stroke, or Transient Ischemic Attack (TIA)?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
3. Within the past 12 months have you taken or been prescribed any of the following: a) Lasix or furosemide or home oxygen for any reason, b) prednisone for any lung condition (including asthma), or c) medications for both diabetes and a heart condition (medication prescribed solely for high blood pressure does not count as a heart medication)?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
4. Within the past 6 months have you consulted a doctor or used any prescribed medication for any shortness of breath, chest pain or angina?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

STEP 5. COVERAGE OPTIONS (Skip if under age 70 on Effective Date)

Check one only per applicant

On the Effective Date indicated on this application, I will be:	I am proceeding as follows:	Applicant 1	Applicant 2
Under Age 70 (Medical Declaration NOT required).	Stable Chronic Condition Option automatically included.	<input type="checkbox"/>	<input type="checkbox"/>
Age 70-85 and I am purchasing the Stable Chronic Condition Option and I have answered NO to all questions on the Medical Declaration above.	I will pay Table 2 rates for the Stable Chronic Condition Option.	<input type="checkbox"/>	<input type="checkbox"/>
Age 70-85 and I am waiving the Stable Chronic Condition Option because: i) I have answered YES to one or more questions on the Medical Declaration above and am ineligible for the Stable Chronic Condition Option, or; ii) I do NOT want or need coverage for my pre-existing conditions.	I will pay Table 1 rates and I waive my rights to the Stable Chronic Condition Option. I understand that claims arising from Stable Chronic Conditions will NOT be paid.	<input type="checkbox"/>	<input type="checkbox"/>
Age 86 or over and I have answered NO to all questions on the Medical Declaration above.	I understand that claims arising from Stable Chronic Conditions will NOT be paid and that my policy deductible is \$500.	<input type="checkbox"/>	<input type="checkbox"/>
Age 86 or over and I have answered YES to one or more questions on the Medical Declaration above.	I understand that I can NOT apply for any Visitor to Canada Insurance with 21st Century.	<input type="checkbox"/>	<input type="checkbox"/>

STEP 6. CALCULATE PREMIUM

Aggregate Policy Limit (check one only)

\$10,000 \$15,000 \$25,000 \$50,000 \$100,000 (+ additional \$50,000 for Injury) \$150,000

Premium Calculation	Applicant 1 or Family	Applicant 2	Applicant 3	Applicant 4
Rate per Day	\$	\$	\$	\$
# of Days	X	X	X	X
Deductible Option for those under age 86 (Check one <input checkbox"="" checked="" type="checkbox/>)</td> <td><input type="/> \$0 (+5%) <input type="checkbox"/> \$50 (0%) <input type="checkbox"/> \$250 (-10%)	<input type="checkbox"/> \$0 (+5%) <input type="checkbox"/> \$50 (0%) <input type="checkbox"/> \$250 (-10%)	<input type="checkbox"/> \$0 (+5%) <input type="checkbox"/> \$50 (0%) <input type="checkbox"/> \$250 (-10%)	<input type="checkbox"/> \$0 (+5%) <input type="checkbox"/> \$50 (0%) <input type="checkbox"/> \$250 (-10%)	
Premium	=	=	=	=

STEP 7. PLEASE READ CAREFULLY before signing (this application must be signed by all applicants or by the sponsor if a Medical Declaration is required)

I/we certify that the information provided on this form is true and accurate, and understand that such information is material to the risk, and constitutes the basis of any coverage offered. I/we fully understand that if any of my/our answers are untrue or incorrect, then coverage offered will be null and void. I/we understand that the Policy contains important terms and conditions of coverage including exclusions and other limitations. I/we understand that Manulife Financial, its agents, third party administrators or its legal representatives may investigate any claim. I/we authorize any hospital, physician or their medical service provider, or any other organization or person that has any records or knowledge of me/us and my/our health to release to third party administrators, and Manulife Financial and its reinsurers, any such information for the purpose of this application, contract and any subsequent claim.

	Applicant/Sponsor Signature	Name of Applicant/Sponsor (please print)	Date (mm/dd/yy)
Applicant 1			
Applicant 2			

STEP 8. PAYMENT

Payment type:	<input type="checkbox"/> Cheque <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> Cash
Credit Card Number:	Expiry Date: mm/yy
Cardholder Name:	Cardholder Signature:

IMPORTANT NOTE: Return this completed form to your agent. **THIS FORM IS NOT AN INSURANCE POLICY; YOUR OFFICIAL POLICY DOCUMENTS MUST BE PROVIDED BY YOUR INSURANCE AGENT.**

Agent use only	Phone#: 1-800-526-7420 or 705-752-1723	Fax to: 1-888-751-5124 or 705-752-51984	Email to: raybattiston@on.aibn.com
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