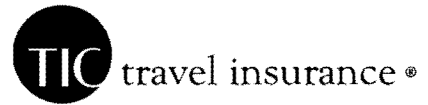


Detailed medical questionnaire



Underwritten by Co-operators Life Insurance Company.

How to complete this form: Complete one form for each person applying for insurance.

- Answer all questions on the form.
- If you're unsure about your answers, please talk to your physician first.
- Applicant, legal guardian or power of attorney must sign and date the form.
- If you have any questions about this form, you can reach us toll-free at: 1-888-298-8151.
- If your application is missing information or isn't signed and dated, we'll have to follow up with you or your agent/broker and it will take longer to process your application.

For the complete terms, conditions, limitations and exclusions please refer to the policy.

Mail, fax or email it back to us

TIC Travel Insurance Coordinators Ltd.
Underwriting Department
250 Yonge Street, Suite 2100
Toronto, Ontario M5B 2L7
Fax: 1-866-256-2377 or
416-340-0790
Email: directuw@travelinsurance.ca

Eligibility

You are eligible to apply for coverage if you meet the eligibility requirements stated below.

Coverage is NOT AVAILABLE to any individual who does not meet eligibility or who:

- a) has been diagnosed with a terminal illness;
- b) has been diagnosed with or has had an episode of congestive heart failure;
- c) has Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV);
- d) has Alzheimer's disease or any other type of dementia;

- e) has received any type of treatment for pancreatic cancer, liver cancer or any type of cancer that has metastasized;
- f) has been prescribed or used home oxygen treatment in the last 12 months;
- g) has had a major organ transplant (heart, kidney, liver, lung);
- h) has received kidney dialysis treatment in the last 12 months.

You are eligible to apply for coverage if you meet the eligibility requirements stated above.

Do you confirm that you are eligible to apply?

NO YES

Applicant Information

Last name: _____ (please print) First name: _____ Date of birth: _____ (mm/dd/yyyy)

Your mailing address Street: _____ Apt #: _____

City: _____ Province: _____ Postal code: _____

Phone: _____ Fax: _____ E-mail: _____

Destination: _____ Date of departure: _____ (mm/dd/yyyy) Date of return: _____ (mm/dd/yyyy)

Single-trip Multi-trip Visitors to Canada Top-Up or Extension

Company name: _____ Policy number: _____

Agent/Broker Information

Who should we contact? Applicant Agent/Broker 2168

Agency/Broker Name: _____ Ager

Please send correspondence by: Fax: _____ E-mail: _____

Attention: _____

Ray Battiston, BA, CAIB, CIP, Insurance Broker
Box 510, 7 Red Haven Drive
St Davids On LOS 1P0
Ph. 1-800-526-7420 or 1-905-262-6575
FAX 1-866-614-8753
IceColdNorth.com
raybattiston@on.aibn.com

Applicant's name (please print)

Date (mm/dd/yyyy)

Check yes if you've ever had symptoms, investigations or treatment for any of the conditions in the group, then check the box beside the specific condition that applies to you. If more than one condition applies, check the box for every condition.

Heart and cardiovascular

- no
yes - please check all that apply

- arrhythmia, fibrillation, palpitations or any irregular heart rate
heart murmur

- chest pain or angina
arteriosclerosis
coronary artery disease
congestive heart failure
by-pass surgery
use pacemaker or defibrillator
valve replacement or abnormality

- heart attack, myocardial infarction
congenital heart defect
prescribed and /or used any form of nitroglycerin
angioplasty or stent
other:

Stroke, cerebrovascular and neurological

- no
yes - please check all that apply

- cerebrovascular accident (CVA), stroke
transient ischemic attack (TIA) or mini-stroke

- ongoing therapy
paralysis
use of cane, walker, wheelchair or other mobility device
hydrocephalus
parkinson's disease
seizures

- migraine
epilepsy
aneurysm
Alzheimer's disease or dementia
mental or nervous disorder, or anxiety
neurological disorder
other:

Lung and respiratory

- no
yes - please check all that apply

- chronic obstructive pulmonary disease (COPD)
asthma

- chronic bronchitis
bronchial asthma
pulmonary embolism
sarcoidosis of lung
sleep apnea
emphysema
asbestosis

- tuberculosis
pulmonary fibrosis
use of home oxygen
use of prednisone
use of cortisone
other:

Internal Conditions

- no
yes - please check all that apply

- liver disease
kidney disorder (including stones)
kidney failure
spleen or pancreatic disorder
gallbladder disorder
prostate disorder

- urinary disorder
ovarian or uterine disorder
artery or vein disorder
peripheral vascular disease
other:

Gastrointestinal conditions

- no
yes - please check all that apply

- esophagus disorder
stomach disorder

- bowel, colon or intestine disorder
ulcer
diverticulitis
diverticulosis
hernia (specify type)

- GERD, heartburn, acid reflux
irritable bowel syndrome (IBS)
ulcerative colitis
Crohn's disease
other:

Cancer

- no
yes - please check all that apply

- Is your cancer eliminated?
no yes

- Location of cancer
Date of last treatment
radiation treatment
chemotherapy
brachytherapy
hormone therapy
surgery

- metastasis
leukemia (specify type):
in remission
no treatment required
treatment declined
other:

Other Conditions

- no
yes - please check all that apply

- Aneurysm: repaired? no yes
Location: abdominal
aortic (AAA)
brain
heart

- diabetes controlled by diet
diabetes - oral medication
diabetes - insulin
blood disorder
idiopathic thrombocytopenic purpura
hemochromatosis
anemia
multiple sclerosis
cystic fibrosis
Lou Gehrig's disease (ALS)
Acquired Immune Deficiency (AIDS) or Human Immunodeficiency Virus (HIV)

- scleroderma
sarcoidosis any location
high blood pressure
high cholesterol
systematic lupus erythematosus
arthritis
osteoporosis, osteopenia
muscle or skeletal disorders
use of prednisone, cortisone
use of walker, cane or mobility device
other:

Applicant's name (please print)

Date (mm/dd/yyyy)

Medical Information

Height: [] ft [] in [] cm Weight: [] lbs [] kg Have you smoked in the last 24 months? [] No [] Yes

Family doctor name: Phone number:

Name of last physician or medical clinic you visited: Phone number: Date you visited: (mm/dd/yyyy)

Reason for visit/results (diagnosis, medications prescribed, follow-up appointments, investigations or treatments, surgery recommended or scheduled):

Have you been advised by a physician to have a test, investigation or surgery that you haven't had yet? [] No [] Yes

Please provide details:

Do you need assistance with activities of daily living? [] No [] Yes (eating, bathing, using the toilet, changing positions (including getting in and out of a bed or chair) and dressing)

Please provide details:

Please tell us about the history of ALL your medical conditions you checked on page 2. We need to know about your symptoms, any investigations, treatments and prescriptions you've had. Attach a separate sheet if necessary.

Table with 5 columns: Medical condition, Medication, Date prescribed, Date of last dosage change, Symptoms/investigation/treatment and date

Have you EVER been hospitalized or had surgery recommended or scheduled? [] No [] Yes

Please provide details:

Table with 3 columns: Medical condition, Treatment, Date (mm/dd/yyyy)

In the last five years, have you been declined life, health or travel insurance or refused renewal of coverage? [] No [] Yes

Please provide details:

Declaration and authorization

Declaration

You declare that: The information you've provided in this questionnaire is truthful, complete and accurate.

You understand that:

- This questionnaire and the answers you provided are part of a contract provided through TIC Travel Insurance Coordinators Ltd.
- If your medical status or any of your answers changes between the date you complete this questionnaire and your departure date or top-up/extension effective date, you must notify TIC Travel Insurance Coordinators Ltd. immediately or your coverage will be null and void.
- The underwriting decision applies regardless of the sales medium and/or channel through which you purchase insurance. If a policy is issued to you that does not include this underwriting decision, it will be considered null and void, any premiums paid will be refunded and no claims will be payable.

- TIC will collect, use and/or disclose your personal information only to provide you with the insurance products and services you've requested, for other uses authorized by you, or as required by law.

You acknowledge that:

- If you misrepresent your medical status in this questionnaire, or if you don't disclose material information about your medical status, or if any of your answers are found to be incorrect or untrue, your coverage will be null and void, your claims won't be paid and your premium will be refunded, even if the material non-disclosure or inaccuracy is not related to the claim reported, and you will be solely responsible for all expenses related to your claim.
- This coverage is subject to exclusions, terms, conditions and limitations that may limit or exclude an amount payable.

Authorization

You authorize:

- Any organization or person that has records or knowledge of your health to give any and all information regarding your health, medical history and treatment to TIC Travel Insurance Coordinators Ltd. or its authorized representatives.

You understand and agree that:

- If you refuse or withdraw this authorization your application will be denied.
- A copy of this authorization and declaration is as valid as the original.

I HAVE READ AND UNDERSTOOD THE IMPORTANT INFORMATION IN THE STATEMENT ABOVE No Yes

Applicant's name (please print)

Date (mm/dd/yyyy)

Signature

Date (mm/dd/yyyy)

You must sign and date this questionnaire or it will be returned to you.