

Important Notice

If your health changes or does not remain *stable* between the date you complete and submit this Medical Questionnaire and your departure date, **you must review the medical questions with your broker or sales agent** to re-assess your eligibility. If you are no longer eligible for the insurance plan you purchased and you fail to contact your broker or sales agent, your claim will be denied, the Insurer will void your policy, and the premium you paid will be refunded. This means no benefits will be covered and you will be responsible for all expenses relating to your sickness or injury, including repatriation costs. If you are purchasing a Multi-Trip Annual Plan and your health changes or does not remain *stable* after the effective date, your medical condition may not be covered (see Pre-Existing Medical Condition Exclusions).

H.: Trip Information

Check the applicable Plan and Qualification you are applying for.

Applicant 1

Plans

Multi-Trip Annual 9-Day 16-Day 30-Day 60-Day
 All-Inclusive Multi-Trip Annual 9-Day 16-Day 30-Day 60-Day
 40-Day PSHCP Supplemental
 Effective Date (D/M/Y): ___/___/___

Single Trip Daily or Top-Up Plan **55-74 Vacation Plan**
 Canada Plan **Single Trip Non-Medical Plan***
 Departure Date (D/M/Y): ___/___/___ * Trip Value: \$ _____
 Expiry Date (D/M/Y): ___/___/___ Effective Date** (D/M/Y): ___/___/___

** If you are purchasing a Top-Up to an existing coverage, the Effective Date will be the day after your existing coverage terminates.

Top-Ups

Name of the other Insurer: _____
 Number of Pre-insured days: _____

Qualification (For Medical Questionnaire Applicants only)

Supreme **Elite** **Preferred** **Advantage** **Standard**

Deductible Options (For Medical Questionnaire Applicants only)

\$0 (+10%) **\$250 US (0%)** \$500 US (-5%)
 \$1,000 US (-10%) \$5,000 US (-30%) \$10,000 US (-45%)

Smoker (For Medical Questionnaire Applicants only)

During the 5 years prior to your application, have you smoked cigarettes? Yes No

Applicant 2

Plans

Multi-Trip Annual 9-Day 16-Day 30-Day 60-Day
 All-Inclusive Multi-Trip Annual 9-Day 16-Day 30-Day 60-Day
 40-Day PSHCP Supplemental
 Effective Date (D/M/Y): ___/___/___

Single Trip Daily or Top-Up Plan **55-74 Vacation Plan**
 Canada Plan **Single Trip Non-Medical Plan***
 Departure Date (D/M/Y): ___/___/___ * Trip Value: \$ _____
 Expiry Date (D/M/Y): ___/___/___ Effective Date** (D/M/Y): ___/___/___

** If you are purchasing a Top-Up to an existing coverage, the Effective Date will be the day after your existing coverage terminates.

Top-Ups

Name of the other Insurer: _____
 Number of Pre-insured days: _____

Qualification (For Medical Questionnaire Applicants only)

Supreme **Elite** **Preferred** **Advantage** **Standard**

Deductible Options (For Medical Questionnaire Applicants only)

\$0 (+10%) **\$250 US (0%)** \$500 US (-5%)
 \$1,000 US (-10%) \$5,000 US (-30%) \$10,000 US (-45%)

Smoker (For Medical Questionnaire Applicants only)

During the 5 years prior to your application, have you smoked cigarettes? Yes No

I.: Premium and Payment

For manual applications, please complete the Premium Calculation page to determine each Applicant's total premium, or visit www.etsinc.com/premiumcalculation/index.html

If you are applying for the Canada Plan, 55-74 Vacation Plan, Single Trip Non-Medical Plan or 40-Day PSHCP Plan, complete the Premium Calculation – Plans without Medical Questionnaire page.

If you are applying for all other plans, complete the Premium Calculation – Plans with Medical Questionnaire page.

Total Premium	\$ Applicant 1	+	\$ Applicant 2	=	\$ TOTAL
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Method of Payment Visa MasterCard AMEX Cheque made payable to the broker or sales agent indicated on the front of this application.

Card Number	Expiry Date (M/Y)	Signature of Cardholder	Date Signed (D/M/Y)
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For Broker / Sales Agent Use Only

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Applicant 1 Policy Number:

Applicant 2 Policy Number:

Date Issued (D/M/Y):

This Application must be completed prior to the effective date. **ONLY YOU** can complete and sign the Medical Questionnaire, not your spouse, broker or sales agent. Should you need to make a correction to your answers pertaining to the medical questions in this Application, please call your broker or sales agent for instructions.

A Personal Information

Your personal information is collected for the purpose of providing you with insurance services, claims analysis and payments. For a copy of the etfs Privacy Policy, please see www.etsinc.com. For Privacy Information, please see www.rsagroup.ca

Applicant 1

First Name

Last Name

Date of Birth (D/M/Y) ____/____/____

Male Female

Applicant 2

First Name

Last Name

Date of Birth (D/M/Y) ____/____/____

Male Female

Home Address

Street

City

Province

Postal Code

Telephone

E-mail

Destination Address

Street

City

Province / State / Country

Postal / Zip Code

Telephone

E-mail (if different from home e-mail)

Emergency Contact

First Name

Last Name

Telephone

B Definitions

Throughout the Medical Questionnaire, defined words are written in *italics*. Please refer to them as they are important definitions.

- Terminal illness:** means that you have a medical condition that is cause for a physician to estimate that you have less than 6 months to live or for which palliative care has been received.
- Metastatic cancer:** means a cancer that has spread from its original site to one or more other area(s) of the body.
- Treated:** means that you have been hospitalized, have been prescribed medication (including prescribed as needed), have taken or are currently taking medication or have undergone a medical or surgical procedure. Note that Aspirin/Entrophen is not considered treatment.
- Stable:** means any medical condition (other than a *minor ailment*) for which all the following statements are true:
 - There has been no new diagnosis, treatment or prescribed medication.
 - There has been no change in treatment or change in medication, including the amount of medication to be taken, how often it is taken, the type of medication or change in treatment frequency or type.
Exceptions: the routine adjustment of Coumadin, Warfarin, insulin or oral medication to control diabetes (as long as they are not newly prescribed or stopped) and a change from a brand name medication to a generic brand medication (provided that the dosage is not modified);
 - There have been no new symptoms, more frequent symptoms or more severe symptoms.
 - There have been no test results showing deterioration.
 - There has been no hospitalization or referral to a specialist (made or recommended) and you are not awaiting the results of further investigations for that medical condition.
- Minor ailment:** means any sickness or injury which does not require: the use of medication for a period of greater than 15 days; more than one follow up visit to a physician, hospitalization, surgical intervention or referral to a specialist; and which ends at least 30 consecutive days prior to the departure date of each trip. However, a chronic condition or complications of a chronic condition are not considered a minor ailment.
- Regular check-up:** means any standard or customary medical examination unrelated to any specific medical condition and which is carried out for the purpose of screening, health monitoring or preventive care and may include routine medical tests and investigations.

I understand that in the event of a claim, the answers I provide herein will be reviewed for accuracy by the Insurer.
If they are inaccurate in any way, my claim will be denied.

C.: Are you eligible?

This insurance is only available if you are a Canadian resident covered by the Government Health Insurance Plan in your province or territory of residence for the entire duration of your trip.

1. Coverage is NOT AVAILABLE to any individual who:

- is travelling against the advice of a physician;
- has been diagnosed with a **Terminal illness** or **Metastatic cancer**;
- has a **Kidney disease** requiring dialysis;
- has been prescribed or used **home oxygen** in the 12 months prior to their application date;
- has been diagnosed with **AIDS** (Acquired Immune Deficiency Syndrome); or
- has been diagnosed with **HIV** (Human Immunodeficiency Virus).

Applicant 1	Applicant 2
<input type="checkbox"/> Eligible	<input type="checkbox"/> Eligible
<input type="checkbox"/> Not Eligible	<input type="checkbox"/> Not Eligible

Please confirm your eligibility to apply for this insurance.

If you are Eligible, please continue to the next section. If you are Eligible and are applying for the Canada Plan, 55-74 Vacation Plan, Single Trip Non-Medical Plan or 40-Day PSHCP Plan, please proceed directly to Section H.

D.: Do you require customized Medical Underwriting?

2. Have you had **Heart bypass surgery** more than 10 years prior to your application date (use the date of the most recent bypass)?

Applicant 1	Applicant 2
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

3. Have you had **Heart angioplasty** (including stent placement) more than 10 years prior to your application date (use the date of the most recent angioplasty)?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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4. Have you ever had a **Bone marrow transplant** or an **Organ transplant** (excluding corneal transplant)?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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5. Do you have an **Aneurysm** of 3.5 cm or more which remains surgically unrepaired?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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6. During the 5 years prior to your application, have you been diagnosed with or *treated* for **Congestive heart failure** or are you currently taking **Lasix**, **Furosemide** or a **water pill** (excluding a water pill taken for high blood pressure only)?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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7. During the 12 months prior to your application, have you had:

a. Any **Heart condition** for which you were hospitalized or required a change in medication? (Refer to part b. of the *stable* definition.)

<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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b. A **Lung condition** (including pneumonia) which required hospitalization or treatment with **Prednisone** (**Deltasone** or other generics)?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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8. During the 12 months prior to your application, have you been diagnosed with or *treated* for 3 or more of the following conditions?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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- **Diabetes** (*treated* with oral medication or insulin)
- **Peripheral vascular disease** (PVD: narrowing or blockage of any blood vessel)
- **Lung condition** (including any prescription for puffers/inhalers) **excluding lung cancer** or a *minor ailment*

- **Heart condition** (including stent placement, pacemaker and/or defibrillator)
- **Stroke** or **Mini-stroke** (CVA/TIA)
- **High blood pressure**

If you have answered YES to ANY question in Section D above, please contact your broker or sales agent. Otherwise, please continue.

E.: Which plan do you qualify for?

9. During the 2 years prior to your application, have you been diagnosed with or *treated* for any of the following:

- **Chronic bowel disease** (such as but not limited to Crohn's disease or Ulcerative colitis)?
- **Gallbladder disease** (including stones)? Not applicable if your gallbladder has been removed.
- **Gastrointestinal bleeding**, **Bowel obstruction** or have had **Bowel surgery**?
- **Kidney disease** (including stones), **Liver disease** or **Pancreatitis**?

Applicant 1	Applicant 2
<input type="checkbox"/> Yes 5 pts <input type="checkbox"/> No	<input type="checkbox"/> Yes 5 pts <input type="checkbox"/> No

10. During the 10 years prior to your application, have you been diagnosed with or *treated* for a **Heart condition** (including stent placement, pacemaker and/or defibrillator)?

<input type="checkbox"/> Yes 5 pts <input type="checkbox"/> No	<input type="checkbox"/> Yes 5 pts <input type="checkbox"/> No
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	Applicant 1	Applicant 2
11. During the 5 years prior to your application, have you been diagnosed with or <i>treated</i> for:		
a. Diabetes (<i>treated</i> with oral medication or insulin or controlled by diet) or Glucose intolerance (pre-diabetes)?	<input type="checkbox"/> Yes 5 pts <input type="checkbox"/> No	<input type="checkbox"/> Yes 5 pts <input type="checkbox"/> No
b. Stroke or Mini-stroke (CVA/TIA)?	<input type="checkbox"/> Yes 5 pts <input type="checkbox"/> No	<input type="checkbox"/> Yes 5 pts <input type="checkbox"/> No
c. Peripheral vascular disease (PVD: narrowing or blockage of any blood vessel)?	<input type="checkbox"/> Yes 5 pts <input type="checkbox"/> No	<input type="checkbox"/> Yes 5 pts <input type="checkbox"/> No
d. Lung condition (such as any prescription for puffers/inhalers) excluding lung cancer or a <i>minor ailment</i> ?	<input type="checkbox"/> Yes 5 pts <input type="checkbox"/> No	<input type="checkbox"/> Yes 5 pts <input type="checkbox"/> No
e. Dementia or Alzheimer's disease ?	<input type="checkbox"/> Yes 5 pts <input type="checkbox"/> No	<input type="checkbox"/> Yes 5 pts <input type="checkbox"/> No
f. Cancer (excluding basal or squamous cell skin cancer or breast cancer <i>treated</i> only with Tamoxifen , Femara or Arimidex)?	<input type="checkbox"/> Yes 5 pts <input type="checkbox"/> No	<input type="checkbox"/> Yes 5 pts <input type="checkbox"/> No
12. Have you ever been diagnosed with or <i>treated</i> for any of the following conditions:	<input type="checkbox"/> Yes 1 pt <input type="checkbox"/> No	<input type="checkbox"/> Yes 1 pt <input type="checkbox"/> No
• Heart condition (including stent, pacemaker and/or defibrillator)?		
• Stroke or Mini-stroke (CVA/TIA)?		
13. Has it been more than 18 months since your last regular check-up with a physician?	<input type="checkbox"/> Yes 1 pt <input type="checkbox"/> No	<input type="checkbox"/> Yes 1 pt <input type="checkbox"/> No
14. During the 12 months prior to your application, have you been diagnosed with or <i>treated</i> for:		
a. High blood pressure ?	<input type="checkbox"/> Yes 1 pt <input type="checkbox"/> No	<input type="checkbox"/> Yes 1 pt <input type="checkbox"/> No
b. High cholesterol ?	<input type="checkbox"/> Yes 1 pt <input type="checkbox"/> No	<input type="checkbox"/> Yes 1 pt <input type="checkbox"/> No
15. During the 5 years prior to your application, have you smoked cigarettes?	<input type="checkbox"/> Yes 0 pts <input type="checkbox"/> No	<input type="checkbox"/> Yes 0 pts <input type="checkbox"/> No
Total Points (Yes answers for Questions 9 to 14)	<input type="text"/>	<input type="text"/>

F.: Qualification Table

PLEASE INDICATE THE COVERAGE YOU QUALIFY FOR and read the Pre-Existing Medical Condition Exclusions.

Total Points	You Qualify for	Pre-Existing Period	Applicant 1	Applicant 2
0	Supreme	90 days	<input type="checkbox"/>	<input type="checkbox"/>
1	Elite	90 days	<input type="checkbox"/>	<input type="checkbox"/>
2 to 4	Preferred	90 days	<input type="checkbox"/>	<input type="checkbox"/>
5 to 9	Advantage	365 days	<input type="checkbox"/>	<input type="checkbox"/>
10 or more	Standard	365 days	<input type="checkbox"/>	<input type="checkbox"/>

Pre-Existing Medical Condition Exclusions

This insurance does not cover losses or expenses caused directly or indirectly, in whole or in part, by:

- Any sickness, injury or medical condition (other than a *minor ailment*) that was not *stable* at any time during the applicable Pre-Existing Period prior to each departure date.
- Your heart condition, if **any** heart condition was not *stable* at any time during the applicable Pre-Existing Period prior to each departure date.
- Your lung condition, if:
 - any** lung condition was not *stable*; or
 - you have been *treated* with home oxygen or taken oral steroids (e.g., prednisone) for **any** lung condition, at any time during the applicable Pre-Existing Period prior to each departure date.

G.: Agreement, Understanding and Authorization

You must read and understand the importance of each of the following statements and **sign below**.

- A PRE-EXISTING MEDICAL CONDITION EXCLUSION** may apply to medical conditions and/or symptoms that existed prior to my trip. I understand that any medical condition I have, including those disclosed in **SECTION E**, will be subject to the Pre-Existing Medical Condition Exclusions as stated above. I will refer to my policy and to the above for the full Pre-Existing Medical Condition Exclusion clause.
- Where I was unsure of my medical history as it relates to the medical questions, I have verified it with my physician. I personally provided the answers on this Medical Questionnaire and I warrant that all information disclosed herein is correct and complete. In the event of a claim, I fully understand that the Insurer will review my prior medical history and these answers and, if any of my answers are incorrect or incomplete, the Insurer will void my policy and my claim will be refused, regardless of whether the incorrect or incomplete question is related to the cause of my claim. I understand that the answers on my Medical Questionnaire are relevant to the risk and constitute the basis of my insurance.
- I understand the necessity of calling Global Excel Management Inc. and obtaining prior approval before seeking medical attention in case of a claim or medical emergency. The toll free telephone number can be found on my wallet card and in my insurance policy.
- Medical Authorization in Case of a Claim – I understand that Royal & Sun Alliance Insurance Company of Canada and Global Excel Management Inc. may investigate my claim. By signing this Medical Questionnaire, I also hereby direct and authorize any physician, health care practitioner, hospital or other medical care facility, pharmacy, the Ministry of Health or any other person who has attended and examined me or who has knowledge or records of me or my health, to furnish to Royal & Sun Alliance Insurance Company of Canada and to Global Excel Management Inc. any or all information with respect to my sickness, injury, medical history, consultations, medicines or treatment and copies of all hospital or medical records for the purpose of investigating my claim.
- I understand that some exclusions may apply and affect my coverage. I will read my insurance policy for additional details.



Applicant 1 Signature

Date of Signature (D/M/Y)



Applicant 2 Signature

Date of Signature (D/M/Y)