.:Medi-Select Advantage®

Emergency Medical Travel Insurance

Application

Administered by : etfs®

Age 55 or over

Effective August 10, 2009

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FOR BROKER/SALES AGENT USE ONLY

APPLICANT 1				*APPLICANT 2*			
Policy Number:		**Date issued (D/M/Y):**		**Policy Number:**		**Date issued (D/M/Y):**	

APPLICATION INFORMATION

This Application must be completed prior to the effective date. ONLY YOU can complete and sign this Application, not your spouse, broker or sales agent.

If you have any doubt about your health as it relates to the eligibility and qualification questions asked, you must consult a physician for advice before completing this Application.

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.

If you are applying for:

- a Multi-Trip Annual Plan or a Single Trip Daily Plan, complete all parts of this Application.
- the Canada Plan, the Vacation Plan (age 55 to 74) or the 40-Day Supplemental Multi-Trip Annual Plan for PSHCP Members, review and complete only the Eligibility Criteria on page 2. If you are eligible, turn to page 4 and complete the Trip Information and Premium Calculation sections.

PERSONAL INFORMATION

Your personal information is collected for the purpose of providing you with insurance services, claims analysis and payments. Call 1-888-830-7460 for a copy of the **etfs** Privacy Policy. For Privacy Information, please see www.rsagroup.ca, or call us at 1-800-716-4339.

APPLICANT 1

Last Name (Maiden Name for Quebec only) First Name

Date of Birth (Day/Month/Year) ☐ Male ☐ Female

APPLICANT 2

Last Name (Maiden Name for Quebec only) First Name

Date of Birth (Day/Month/Year) ☐ Male ☐ Female

HOME ADDRESS:

Street: City: Province:

Postal Code: E-mail: Tel.: ( )

DESTINATION ADDRESS:

Street: City: Province / State:

Postal / Zip Code: E-mail: Tel.: ( )

Emergency Contact Name: Tel.: ( )

DEFINITIONS

The following words appear throughout this application with the reference notations 1 through 4. Please refer to them as they are important definitions.

1. **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.
2. **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.
3. **Stable**: means any medical condition (other than a minor ailment[1]) for which all the following statements are true:
   a. there has been no new diagnosis, treatment or prescribed medication;
   b. 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);
   c. there have been no new symptoms, more frequent symptoms or more severe symptoms;
   d. there have been no test results showing deterioration;
   e. 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.
4. **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.

Medi-Select Advantage® Emergency Medical Travel Insurance is underwritten by Royal & Sun Alliance Insurance Company of Canada and administered by Expert Travel Financial Security (E.T.F.S.) Inc.
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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.

ELIGIBILITY CRITERIA

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**.	*APPLICANT 1*		*APPLICANT 2*	
	YES	NO	YES	NO
1. ***Are you:***				
a) Travelling against the advice of a physician?	☐	☐	☐	☐
2. *Have you **ever** been **diagnosed** with:*				
a) A **Terminal illness**? A **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.	☐	☐	☐	☐
b) **Metastatic cancer**? **Metastatic cancer** means a cancer that has spread from its original site to one or more other area(s) of the body.	☐	☐	☐	☐
c) **AIDS** (Acquired Immune Deficiency Syndrome) or **HIV** (Human Immunodeficiency Virus)?	☐	☐	☐	☐
3. *During the **12 months** prior to the date of your application, have you been **prescribed** or **used**:*				
a) **Home oxygen**?	☐	☐	☐	☐
4. *Do you **have**:*				
a) A **Kidney disease** requiring **dialysis**?	☐	☐	☐	☐

- If you answered **NO** to **ALL** questions in **ELIGIBILITY CRITERIA**, please proceed to **PLAN ELIGIBILITY** below.
- If you have a **YES** answer to **ANY** question in **ELIGIBILITY CRITERIA**, you are **NOT ELIGIBLE** to purchase this insurance.

PLAN ELIGIBILITY

	APPLICANT 1		*APPLICANT 2*	
5. *Have you **ever had**:*	YES	NO	YES	NO
a) A **Bone marrow transplant** or an **Organ transplant** (excluding corneal transplant)?	☐	☐	☐	☐
6. *Has it been more than **10 years** from the date of your application since you **had**:*				
a) **Heart bypass surgery** (use the date of the most recent bypass)?	☐	☐	☐	☐
b) **Heart angioplasty,** including stent placement (use the date of the most recent angioplasty)?	☐	☐	☐	☐
7. *During the **5 years** prior to the date of your application, have you been **diagnosed** with or **treated**[4] for:*				
a) **Congestive heart failure** or are you **currently** taking **Lasix** or **Furosemide?**	☐	☐	☐	☐
b) **Water on lungs** or **ankle** or **leg swelling** for which you have taken **Lasix**, **Furosemide** or a water pill (excluding a water pill taken for high blood pressure)?	☐	☐	☐	☐
8. *During the **12 months** prior to the date of your application, have you been **diagnosed** with or **been hospitalized** for:*				
a) A new **Heart condition**, or had an existing **Heart condition** which required hospitalization or a change in medication? (refer to DEFINITIONS 3. stable (b))	☐	☐	☐	☐
9. *During the **12 months** prior to the date of your application, **have** you **had**:*				
a) A **Lung condition** (including **pneumonia**) which required hospitalization or treatment with **Prednisone** (**Deltasone** or other generics)?	☐	☐	☐	☐
10. *During the **12 months** prior to the date of your application, have you been **diagnosed** with or **treated**[4] for **3 or more** of the following **medical conditions**:*	☐	☐	☐	☐
• **Heart condition** (including pacemaker)? • **Stroke** (CVA) or **mini-stroke** (TIA)? • **High blood pressure**? • **Dementia** or **Alzheimer's disease**? • **Lung condition** (including any prescription for puffers / inhalers) excluding a minor ailment[1]? • **Diabetes** (treated with oral medication or insulin)? • **Peripheral vascular disease** (PVD: narrowing or blockage of any blood vessel)?				
11. *Do you **have**:*				
a) An **Aneurysm** of 3.5 cm or more which remains surgically untreated?	☐	☐	☐	☐

- If you answered **NO** to **ALL** questions in **PLAN ELIGIBILITY**, please proceed to **PLAN QUALIFICATION** below.
- If you have a **YES** answer to **ANY** question in **PLAN ELIGIBILITY**, you are **NOT ELIGIBLE** to purchase this insurance. Other insurance coverage options may be available; please contact your broker or sales agent.

PLAN QUALIFICATION

PART A

	PART A			
12. *During the **5 years** prior to the date of your application, **have you**:*	YES	NO	YES	NO
a) **Smoked cigarettes?**	☐	☐	☐	☐

PART B

	PART B			
13. *During the **10 years** prior to the date of your application, have you been **diagnosed** with or **treated**[4] for:*	YES	NO	YES	NO
a) A **Heart condition** (including pacemaker)?	☐	☐	☐	☐
14. *During the **5 years** prior to the date of your application, have you been **diagnosed** with or **treated**[4] for **any** of the following **medical conditions**:*				
a) **Stroke** (CVA) or **mini-stroke** (TIA)?	☐	☐	☐	☐
b) **Diabetes** (treated with oral medication or insulin)?	☐	☐	☐	☐
c) **Peripheral vascular disease** (PVD: narrowing or blockage of any blood vessel)?	☐	☐	☐	☐
d) Both **High blood pressure** and **high cholesterol**, only if you answered YES to any of the medical conditions listed in questions 13 a), 14 a), 14 b) or 14 c)?	☐	☐	☐	☐
e) **Lung condition** (including any prescription for puffers / inhalers) excluding a minor ailment[1]?	☐	☐	☐	☐
f) **Dementia** or **Alzheimer's disease**?	☐	☐	☐	☐
g) **Cancer** (excluding basal or squamous cell skin cancer or breast cancer treated only with **Tamoxifen**, **Femara** or **Arimidex**)?	☐	☐	☐	☐

PART B (continued)

15. *During the **2 years** prior to the date of your application, have you been **diagnosed** with or **treated**[4] for **any** of the following **medical conditions**:*	PART B YES	PART B NO	PART B YES	PART B NO
a) **Chronic bowel disease** (such as but not limited to **Crohn's disease** or **Ulcerative colitis**)?	☐	☐	☐	☐
b) **Gastrointestinal bleeding, bowel obstruction** or have you had **bowel surgery**?	☐	☐	☐	☐
c) **Gallbladder disease** (such as stones)? If your gallbladder has been removed, answer NO.	☐	☐	☐	☐
d) **Liver disease**?	☐	☐	☐	☐
e) **Pancreatitis**?	☐	☐	☐	☐
f) **Kidney disease** (including stones)?	☐	☐	☐	☐
g) **Diabetes** (treated only with diet) or **glucose intolerance** (pre-diabetes)?	☐	☐	☐	☐

- If you answered **NO** to **ALL** questions in **PART B**, please proceed to **PART C** below.
- If you have **1 YES** answer in **PART B**, you qualify for **ADVANTAGE**. Please skip the remaining questions and proceed to the **QUALIFICATION TABLE**.
- If you have **2 or more YES** answers in **PART B**, you qualify for **STANDARD**. Please skip the remaining questions and proceed to the **QUALIFICATION TABLE**.

PART C

16. *Have you **ever** been **diagnosed** with or **treated**[4] for **any** of the following **medical conditions**:*	PART C YES	PART C NO	PART C YES	PART C NO
• **Heart condition** (excluding extra beats or palpitations for which you have not been treated[4])? • **Stroke** (CVA) or **mini-stroke** (TIA)? • **Lung condition** (including any prescription for puffers / inhalers) excluding a minor ailment[1]?	☐	☐	☐	☐
17. *Has it been more than **18 months** since you **had** a:*				
a) **Regular check-up**[2] with a physician?	☐	☐	☐	☐
18. *During the **12 months** prior to the date of your application, have you been **diagnosed** with or **treated**[4] for:*				
a) **High blood pressure**?	☐	☐	☐	☐
b) Any **medical condition** excluding a minor aliment[1] not specifically mentioned in this Application ?	☐	☐	☐	☐

- If you answered **NO** to **ALL** questions in **PARTS A**, **B**, and **C,** you qualify for **SUPREME**. Please proceed to the **QUALIFICATION TABLE**.
- If you answered **YES** to the question in **PART A** and **NO** to **ALL** questions in **PARTS B** and **C**, you qualify for **ELITE**. Please proceed to the **QUALIFICATION TABLE**.
- If you answered **YES** or **NO** to the question in **PART A** and you have **1 YES** answer in **PART C,** you qualify for **ELITE**. Please proceed to the **QUALIFICATION TABLE**.
- If you answered **YES** or **NO** to the question in **PART A** and you have **2 or more YES** answers in **PART C,** you qualify for **PREFERRED**. Please proceed to the **QUALIFICATION TABLE**.

QUALIFICATION TABLE

PLEASE INDICATE YOUR QUALIFICATION AND READ THE PRE-EXISTING MEDICAL CONDITION EXCLUSIONS.

IF YOU QUALIFY FOR:	PRE-EXISTING PERIOD	PRE-EXISTING MEDICAL CONDITION EXCLUSIONS	*APPLICANT 1*	*APPLICANT 2*
SUPREME	90 days	1, 2, 3	☐	☐
ELITE	90 days	1, 2, 3	☐	☐
PREFERRED	90 days	1, 2, 3	☐	☐
ADVANTAGE	365 days	1, 2, 3	☐	☐
STANDARD	365 days	1, 2, 3	☐	☐

PRE-EXISTING MEDICAL CONDITION EXCLUSIONS

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

1. Any sickness, injury or medical condition (other than a minor ailment[1]) that was not stable[3] at any time during the applicable Pre-existing Period prior to each departure date.
2. Your heart condition, if **any** heart condition was not stable[3] at any time during the applicable Pre-existing Period prior to each departure date.
3. Your lung condition, if:
   a) **any** lung condition was not stable[3]; or
   b) 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.

IMPORTANT NOTICE: If your health changes or does not remain stable[3] between the date you complete and submit this Application 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. However, if you are purchasing a Multi-Trip Annual Plan and your health changes or does not remain stable[3] after the effective date, your medical condition may not be covered (see Pre-existing Medical Condition Exclusions).

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 the **Plan Qualification**, 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 Application 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 Application 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 Application, 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 *Last Name / First Name (Please Print):* ________ *Signature:* ________ *Date (D/M/Y) :* ___ / ___ / ___

APPLICANT 2 *Last Name / First Name (Please Print):* ________ *Signature:* ________ *Date (D/M/Y) :* ___ / ___ / ___

TRIP INFORMATION

APPLICANT 1

PLAN TYPE

Multi-Trip Annual Plan

☐ 9 days ☐ 16 days
☐ 30 days ☐ 60 days

Effective Date (D/M/Y): _____/_____/_____

☐ **40-day PSHCP Supplemental**

Effective Date (D/M/Y): _____/_____/_____

All-Inclusive Multi-Trip Annual Plan

☐ 9 days ☐ 16 days
☐ 30 days ☐ 60 days

Effective Date (D/M/Y): _____/_____/_____

Single Trip Daily Plan

☐ Single Trip with Medical Declaration
☐ Canada Plan
☐ 55 to 74 Vacation Plan

Departure Date (D/M/Y): _____/_____/_____
* EffectiveDate (D/M/Y): _____/_____/_____
Expiry Date (D/M/Y): _____/_____/_____

Deductible Options (US$)

☐ $0 ☐ $250 ☐ $500 ☐ $1,000 ☐ $5,000 ☐ $10,000

APPLICANT 2

PLAN TYPE

Multi-Trip Annual Plan

☐ 9 days ☐ 16 days
☐ 30 days ☐ 60 days

Effective Date (D/M/Y): _____/_____/_____

☐ **40-day PSHCP Supplemental**

Effective Date (D/M/Y): _____/_____/_____

All-Inclusive Multi-Trip Annual Plan

☐ 9 days ☐ 16 days
☐ 30 days ☐ 60 days

Effective Date (D/M/Y): _____/_____/_____

Single Trip Daily Plan

☐ Single Trip with Medical Declaration
☐ Canada Plan
☐ 55 to 74 Vacation Plan

Departure Date (D/M/Y): _____/_____/_____
* EffectiveDate (D/M/Y): _____/_____/_____
Expiry Date (D/M/Y): _____/_____/_____

Deductible Options (US$)

☐ $0 ☐ $250 ☐ $500 ☐ $1,000 ☐ $5,000 ☐ $10,000

Note: Deductible Options apply only to the Multi-Trip Annual Plan and the Single Trip with Medical Declaration Plan.

* If you are adding this insurance as a top up to an existing coverage, the Effective Date will be the day after your existing coverage terminates.

Please indicate the name of the other insurer: ____________________ and the number of insured days ______.

PREMIUM CALCULATION and METHOD OF PAYMENT

	APPLICANT 1	APPLICANT 2
PLEASE REFER TO THE RATE SHEET FOR THE PREMIUMS		
1. **Multi-Trip Annual Premium**		
a) Your premium from the respective rate table: *located on your rate sheet*	a) $ _______	a) $ _______
b) If you have smoked cigarettes during the **5 years** prior to your effective date, add 20% of your premium: *1.2 x line a)*	b) $ _______	b) $ _______
c) For the All-Inclusive Multi-Trip Annual Plan, calculate the appropriate tax portion based on line b) (Ontario 8%, Quebec 9%): *Tax x line b)*	c) $ _______	c) $ _______
d) Multi-Trip Annual Subtotal: *line b) + line c)*	$ _______	$ _______
2. **Single Trip Daily and/or Top Up**		
a) Total trip duration	a) _____ days	a) _____ days
b) Existing coverage, if applicable	b) _____ days	b) _____ days
c) Travel days covered by a Single Trip Daily Plan: *line a) – line b)*	c) _____ days	c) _____ days
d) Single Trip Daily Plan rate based on total trip duration: *located on your rate sheet*	d) $ _______	d) $ _______
e) Single Trip Daily and/or Top Up Premium: *line c) x line d)*	e) $ _______	e) $ _______
f) If you have smoked cigarettes during the **5 years** prior to your effective date, add 20% of your premium (not applicable to the Canada Plan or the 55 to 74 Vacation Plan): *1.2 x line e)*	f) $ _______	f) $ _______
g) Single Trip Daily and/or Top Up Subtotal: *line e) + line f).*	$ _______	$ _______
3. Subtotal of lines 1 to 2: *line 1 d) + line 2 g)*	$ _______	$ _______
4. Deductible options (add or subtract the appropriate % located on your rate sheet): *line 3± surcharge/discount%*	$ _______	$ _______
5. Travel Companion Discount: If applicable, subtract 5% of line 4 for the respective applicant (refer to rate sheet for details): *0.95 x line 4*	$ _______	$ _______
6. Top Up Surcharge: Indicate $25 if you are topping up another carrier's coverage	$ _______	$ _______
7. TOTAL TRAVEL INSURANCE PREMIUM: ***line 5 + line 6***	$	$

TOTAL PAYMENT SUBMITTED FOR APPLICANT 1 AND APPLICANT 2 (The minimum premium is $25 per person, per plan) $

METHOD OF PAYMENT: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Diners - En Route ☐ 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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