

### for International Students

Your personal information is collected for the purpose of providing you with insurance services, claims analysis and payments. Call 1-800-891-0370 for a copy of the **etfs** Privacy Statement. For Privacy Information, please see [www.royalsunalliance.ca](http://www.royalsunalliance.ca), or call us at 1-800-716-4339.

#### For more information, contact:

**Ray Battiston, BA, CAIB, CIP** 1-800-526-7420  
**Insurance Broker** Local: 705-752-1723  
 151 Osprey Crescent Fax: 705-752-5198  
 Callander, Ontario POH 1H0 **raybattiston@on.aibn.com**  
 CANADA **www.iceColdNorth.com**



# Application

To be eligible for coverage under this plan:

1. The applicant must:
  - a) be 65 years old or less; and
  - b) not be eligible for a provincial or territorial health insurance plan in Canada; and
2. The applicant must:
  - a) be a student and provide proof of admission in a recognized Canadian institution of learning; or
  - b) be a student completing post-doctorate research in a recognized Canadian institution of learning.
3. The applicant's spouse and child(ren) may be covered if the appropriate premium is paid. (See definitions of spouse and child(ren) on the back.)

### APPLICANT INFORMATION

<input type="checkbox"/> F		<input type="checkbox"/> M		Last Name: _____		First Name: _____	
Country of Origin: _____				Date of Birth (D/M/Y): / /		Date of Arrival in Canada (D/M/Y): / /	
Please enclose proof of admission and registration at a recognized Canadian institution of learning.		School Name: _____		Date of Enrollment (D/M/Y): / /			
Address in Canada: _____						Apt: _____	
City: _____				Province: _____		Postal Code: _____	
Phone Number: _____			Fax Number: _____			Email: _____	
Beneficiary in case of death: _____							

### DEPENDENT INFORMATION

Spouse: <input type="checkbox"/> Legally married <input type="checkbox"/> Residing together for at least the last 12 months		Date of Arrival in Canada (D/M/Y): / /	
LAST NAME	FIRST NAME	DATE OF BIRTH (D/M/Y)	SEX
Spouse: _____	_____	_____	F <input type="checkbox"/> M <input type="checkbox"/>
Child: _____	_____	_____	F <input type="checkbox"/> M <input type="checkbox"/>
Child: _____	_____	_____	F <input type="checkbox"/> M <input type="checkbox"/>
Child: _____	_____	_____	F <input type="checkbox"/> M <input type="checkbox"/>

### INSURANCE PERIOD and PAYMENT MODE

Desired Effective Date (D/M/Y): / /		Termination Date (D/M/Y): / /		Number of months of coverage: _____		Total Premium Due: _____	
<input type="checkbox"/> Cash		<input type="checkbox"/> Certified Cheque / Money Order					
<input type="checkbox"/> Visa		<input type="checkbox"/> Master Card		<input type="checkbox"/> Diners		<input type="checkbox"/> American Express	
Credit Card Number: _____						Expiry Date (M/Y): ____/____	
Cardholder's Signature:  _____							

### MEDICAL AUTHORIZATION and DECLARATION

I understand that I must purchase the policy within 30 days from the earlier of the date of my arrival in Canada, or the date of my enrolment at a recognized Canadian institution of learning. I understand that if I am presently insured under an insurance policy administered by **etfs**, I must pay the insurance premium prior to the termination date of my existing policy. If I do not satisfy the above conditions, I understand that I will not be covered for a sickness occurring during the first 30 days of this insurance coverage.

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.

Applicant's Signature: \_\_\_\_\_ Date (D/M/Y): \_\_\_\_/\_\_\_\_/\_\_\_\_

### FOR OFFICE USE ONLY

Effective Date (D/M/Y): / /		Policy Number: _____	
Expiry Date (D/M/Y): / /		Premium Paid: _____ <input type="checkbox"/> 30-Day Penalty	

## RATE SCHEDULE

MONTHS	Individual Coverage	Student with 1 dependent	Student with 2 or 3 dependents	Student with 4 or more dependents
<b>12</b>	<b>\$628</b>	<b>\$1,381</b>	<b>\$2,679</b>	<b>\$3,751</b>
<b>11</b>	<b>\$623</b>	<b>\$1,368</b>	<b>\$2,649</b>	<b>\$3,714</b>
<b>10</b>	<b>\$570</b>	<b>\$1,253</b>	<b>\$2,427</b>	<b>\$3,401</b>
<b>9</b>	<b>\$519</b>	<b>\$1,138</b>	<b>\$2,204</b>	<b>\$3,087</b>
<b>8</b>	<b>\$466</b>	<b>\$1,023</b>	<b>\$1,981</b>	<b>\$2,774</b>
<b>7</b>	<b>\$414</b>	<b>\$907</b>	<b>\$1,759</b>	<b>\$2,461</b>
<b>6</b>	<b>\$362</b>	<b>\$793</b>	<b>\$1,535</b>	<b>\$2,148</b>
<b>5</b>	<b>\$305</b>	<b>\$666</b>	<b>\$1,293</b>	<b>\$1,807</b>
<b>4</b>	<b>\$247</b>	<b>\$540</b>	<b>\$1,049</b>	<b>\$1,466</b>
<b>3</b>	<b>\$189</b>	<b>\$414</b>	<b>\$805</b>	<b>\$1,125</b>
<b>2</b>	<b>\$126</b>	<b>\$276</b>	<b>\$537</b>	<b>\$750</b>
<b>1</b>	<b>\$63</b>	<b>\$138</b>	<b>\$269</b>	<b>\$375</b>

The rates and products described are subject to change without notice at any time.

### DEFINITIONS

**"Child(ren)"** means an unmarried child of the principal insured or his/her spouse, who is dependent on the principal insured for support, provided that such child is 22 years old or less on the date of application, or is 25 years old or less provided it can be proven that the child is a full-time student, or is over 22 years of age and has a permanent physical impairment or a permanent mental deficiency on the date of application.

**"Spouse"** means the person, aged 65 or less, to whom the principal insured is legally married or with whom the principal insured has been residing for at least the last 12 months.