



## Underwriting Assessment

RAY BATTISTON, BA, CAIB, CIP  
 INSURANCE BROKER  
 151 OSPREY CRES.  
 CALLANDER, ONTARIO P0H 1H0  
 CANADA

1-800-526-7420  
 LOCAL: 705-752-1723  
 FAX: 705-752-5198  
 raybattiston@on.aibn.com  
 www.IceColdNorth.com

**FORM 1 — APPLICATION AND MEDICAL QUESTIONNAIRE (To be completed by physician)**

10 23 MU1 ECA 0809 000

**For Broker or Sales Agent's use only:**

Company Name: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Tel. Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Part A CLIENT INFORMATION**

Name: \_\_\_\_\_ Date of Birth (d/m/y): \_\_\_\_\_ Tel. Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Address: \_\_\_\_\_ E-mail: \_\_\_\_\_

Travel Dates Departure (d/m/y): \_\_\_\_\_ Return (d/m/y): \_\_\_\_\_ Trip Duration: \_\_\_\_\_ days

Exact Destination City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

**Personal information:** Your personal information is collected for the purpose of providing you with insurance services, claims analysis and payments. Call 1-800-680-3837 for a copy of the **etfs** Privacy Policy. For information, please see [www.rsagroup.ca](http://www.rsagroup.ca), or call us at 1-800-716-4339.

**Note:** The masculine gender is used in this document for the sole purpose of lightening the text.

**Part B MESSAGE TO THE PHYSICIAN**

*In taking time to fill out this questionnaire\*, you are helping your patient to obtain the proper emergency health insurance while he is travelling. Proper coverage will safeguard your patient's financial security.*

The answers you provide regarding your patient's health status will help us to determine his eligibility to purchase travel insurance. Although he does not qualify for our regular insurance plan, we may be able to offer the applicant a modified travel insurance program.

Please include any relevant information you feel may help us assess this patient's medical stability. If you feel your patient's condition is too unstable for him to travel this year, please discuss this matter with him and advise us in Part D - Comments. We appreciate your cooperation.

**\*Charges levied for the completion of this document remain the patient's responsibility.**

**Part C QUESTIONNAIRE (Please type or print clearly)**

List all diagnoses and medical and/or surgical conditions	Date of initial presentation	List all current medications	Date of initial prescription	Medication changes (including dosage and date) in the last 12 months	
				Medication	Dates

1. Has your patient taken **Lasix or other diuretic** in the last 5 years?  yes  no If yes, please provide date & dosage \_\_\_\_\_  
 If so, for what condition?  CHF  HTN  Peripheral Edema  Other (please specify): \_\_\_\_\_
2. Does your patient take an **ACE-inhibitor**?  yes  no  
 If so, for what condition?  CHF  HTN  Other (please specify): \_\_\_\_\_
3. List any other therapy required during the past **3 years** (e.g. home oxygen, chemo, radiation therapy, etc.).  
 Therapy: \_\_\_\_\_ Date or period of treatment (d/m/y): \_\_\_\_\_  
 Therapy: \_\_\_\_\_ Date or period of treatment (d/m/y): \_\_\_\_\_  
 Therapy: \_\_\_\_\_ Date or period of treatment (d/m/y): \_\_\_\_\_
4. List all hospitalizations during the past **3 years**.  
 Date of hospitalization: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
 Date of hospitalization: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
 Date of hospitalization: \_\_\_\_\_ Diagnosis: \_\_\_\_\_
5. List all major tests and investigations during the past **2 years** (e.g. cardiac stress test, cardiac catheterization, scans). **Please include a copy of the test results.**  
 List other recent significant tests (e.g. Hgb for anemia, creatinine for renal insufficiency, LFTs for cirrhosis, etc.).  
 Test/investigation: \_\_\_\_\_ Date (d/m/y): \_\_\_\_\_ Results: \_\_\_\_\_  
 Test/investigation: \_\_\_\_\_ Date (d/m/y): \_\_\_\_\_ Results: \_\_\_\_\_  
 Test/investigation: \_\_\_\_\_ Date (d/m/y): \_\_\_\_\_ Results: \_\_\_\_\_  
**Ejection fraction** (if known): % \_\_\_\_\_ Date (d/m/y): \_\_\_\_\_ **Smoking status:**  yes  no
6. Is the patient awaiting investigations, surgery or any other treatment?  
 yes  no If so, please specify the **type** and the **date** (d/m/y): \_\_\_\_\_
7. Has your patient ever undergone a **Coronary Artery Bypass Graft**?  yes  no Date (m/y): \_\_\_\_\_  
**Angioplasty**?  yes  no Date (m/y): \_\_\_\_\_  
**Stenting**?  yes  no Date (m/y): \_\_\_\_\_
8. Has the patient ever had a functional **cardiac classification** for **Angina**?  yes  no  
 If so, what is the patient's **CURRENT class** of **Angina**?  I  II  III  IV Date of last episode (d/m/y): \_\_\_\_\_
9. Has the patient ever been diagnosed or treated for **Congestive Heart Failure**?  yes  no  
 If so, what is the patient's **CURRENT class** of **Congestive Heart Failure**?  I  II  III  IV Date of last episode (d/m/y): \_\_\_\_\_

**Part D**

**COMMENTS**

**Part E**

**PHYSICIAN INFORMATION**

How long has the applicant been your patient (d/m/y)? \_\_\_\_\_ Are you this patient's family physician, specialist or other? \_\_\_\_\_  
 Physician's name: \_\_\_\_\_ Address: \_\_\_\_\_  
 Prof. No.: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ DATE (d/m/y): \_\_\_\_\_

**THIS FORM MUST BE RETURNED TO:** Medical Underwriting, 73 Queen Street, Sherbrooke, Québec J1M 0C9 / Tel.: 1-800-680-3837 / Fax: 819-566-8067

