MEDICARE INTERNATIONAL TRAVEL INSURANCE

Policy # _____

MEDICAL QUESTIONNAIRE - AGE 55 OR OVER ONLY

Applicant 1 Name	Date of Birth	Applicant 2 Name	Date of Birth
PLEASE PRINT	MM/DD/YY	PLEASE PRINT	MM/DD/YY

ABOUT THE MEDICAL QUESTIONS – Medical questions help us to determine eligibility, assess risk and determine the premium rate that is appropriate.
If you are uncertain of your answers to any of the medical questions, please consult your doctor before completing this application for insurance.

ELIGIBILITY

	Applicant 1	Applicant 2
1. Have you been advised by a physician not to travel at this time?	❑ Yes ❑ No	❑ Yes ❑ No
2. Do you require kidney dialysis?	❑ Yes ❑ No	❑ Yes ❑ No
3. Have you **ever** had a bone marrow or organ transplant (excluding corneal transplant)?	❑ Yes ❑ No	❑ Yes ❑ No
4. Have you had a heart bypass or heart valve surgery more than **ten (10) years** ago?	❑ Yes ❑ No	❑ Yes ❑ No
5. In the last **five (5) years**, have you been diagnosed with and/or had treatment for metastatic cancer?	❑ Yes ❑ No	❑ Yes ❑ No
6. In the last **six (6) months**, have you received chemotherapy and/or radiotherapy and/or other treatment, other than routine follow-up, for cancer (**except** basal cell and squamous cell skin cancer, and breast cancer treated only with hormonal therapy)?	❑ Yes ❑ No	❑ Yes ❑ No
7. In the last **twelve (12) months**, have you been prescribed or taken Prednisone or oxygen, or been hospitalized (as an in-patient or seen in the emergency department) for a lung condition?	❑ Yes ❑ No	❑ Yes ❑ No
8. In the last **two (2) years**, have you: a) been prescribed or taken Lasix or Furosemide for any reason? b) had congestive heart failure?	❑ Yes ❑ No	❑ Yes ❑ No
9. In the last **twelve (12) months**, have you been hospitalized (as an in-patient or seen in the emergency department) for a heart condition?	❑ Yes ❑ No	❑ Yes ❑ No
10. **In the last four (4) months**, have you been prescribed or taken **six (6) or more** prescription medications? **Do not count** the following medications: hormone replacement therapy (thyroid or menopausal); drugs used for osteoporosis, or traveller's diarrhea; or any form of immunization. **Do not count** topical medications that go in your ears or eyes or on your scalp or skin **except:** any form of nitroglycerine or any drug(s) for angina.	❑ Yes ❑ No	❑ Yes ❑ No
11. In the last **three (3) years**, have you been diagnosed and/or had treatment for and/or been hospitalized (as an in-patient or seen in the emergency department) and/or been prescribed or taken medication for any **two (2)** of the following (If you only have **one (1)** of the following conditions, answer **NO**): • Heart condition • Lung condition (medication includes puffer(s)/inhaler(s) **except** a single unrepeated prescription used for a single episode) • Diabetes (treated with oral medication and/or insulin) • Stroke/CVA (cerebrovascular accident) or mini-stroke/TIA (including the use of aspirin/Entrophen for this condition) • Peripheral vascular disease (blocked or narrowed arteries)?	❑ Yes ❑ No	❑ Yes ❑ No

ELIGIBILITY REQUIREMENT. If you answered **"YES"** to ANY of the above questions, you are **not eligible** to purchase this insurance. **DO NOT** complete this application. Contact your agent/broker or 21st Century Travel Insurance to obtain a quote for the Individual Medical Underwriting Plan. If you answered **"NO"** to ALL of the above questions, you are **eligible** to purchase this insurance. Proceed to FIND YOU RATE CATEGORY.

FIND YOUR RATE CATEGORY

Part 1 – Rate qualification	Applicant 1	Applicant 2
1. In the **last five (5) years**, have you been diagnosed with and/or had treatment and/or been hospitalized (as an in-patient or seen in the emergency department) and/or been prescribed or taken medication for: • Heart condition • Stroke/CVA (cerebrovascular accident) or mini-stroke/TIA (transient ischemic attack) including use of aspirin/Entrophen for this condition • Aneurysm • Peripheral vascular disease (blocked or narrowed arteries) • Diabetes (if treated with medication and/or insulin) • Lung condition (medication includes any puffer(s)/inhalers(s) **except** a single unrepeated prescription used for a single episode) • Cirrhosis of the liver?	❑ Yes ❑ No	❑ Yes ❑ No
2. In the last **five (5) years**, have you smoked or used tobacco products **and** been prescribed or used any puffer(s)/inhaler(s)?	❑ Yes ❑ No	❑ Yes ❑ No
3. In the last **two (2) years**, have you been diagnosed with and/or received treatment and/or been hospitialized (as an in-patient or seen in the emergency department) and/or been prescribed or taken medication for **more than one (1)** of the following conditions or **more than (1) episode** of the following conditions: • Bowel obstruction or surgery • Diverticular disorder requiring prescription medication or surgery • Gastrointestinal bleeding • Bleeding or perforated ulcer(s) • Chronic bowel disorder • Liver disorder • Pancreatitis • Kidney disorder (including stones) • Gall bladder disorder (including stones. If gall bladder has been removed, answer **NO**)?	❑ Yes ❑ No	❑ Yes ❑ No
4. In the last **six (6) months**, have you received advice or treatment **more than once** in the emergency room of a hospital?	❑ Yes ❑ No	❑ Yes ❑ No
5. In the last **three (3) months**, have you been prescribed or taken a total of **three (3) or more** medications for high blood pressure (hypertension) and/or a heart condition?	❑ Yes ❑ No	❑ Yes ❑ No

If you answered **"YES"** to ANY of the questions in Part 1, you qualify for Rate Category C. If you answered **"NO"** to ALL the questions in Part 1, proceed to Part 2.

Part 2 – Rate qualification	Applicant 1	Applicant 2
1. Have you **ever** been diagnosed with and/or received treatment for, and/or been hospitalized and/or taken medication for dementia or Parkinson's disease?	❑ Yes ❑ No	❑ Yes ❑ No
2. In the last **twelve (12) months**, have you been prescribed or used a puffer/inhaler?	❑ Yes ❑ No	❑ Yes ❑ No
3. In the last **two (2) years**, have you been diagnosed with or received treatment for and/or been hospitalized (as an in-patient or seen in the emergency department) and/or been prescribed or taken medication for **any** of the following conditions: • A blood disorder treated by a Hematologist or an Internist • Bowel obstruction or surgery • Diverticular disorder requiring prescription medication or surgery • Gastrointestinal bleeding • Bleeding or perforated ulcer(s) • Chronic bowel disorder • Liver disorder • Pancreatitis • Kidney disorder (including stones) • Gall bladder disorder (including stones. If gall bladder has been removed, answer **NO**)?	❑ Yes ❑ No	❑ Yes ❑ No
4. In the last **twelve (12) months**, have you been diagnosed with or received treatment for cancer other than routine follow-up (**except** basal cell and squamous cell skin cancer, and breast cancer treated only with hormonal therapy)?	❑ Yes ❑ No	❑ Yes ❑ No
5. Are you over 65, **and** have you had a fall that you reported to a physician in the last **six (6) months**?	❑ Yes ❑ No	❑ Yes ❑ No

If you answered **"YES"** to ANY of the questions in Part 2, you qualify for Rate Category B. If you answered **"NO"** to ALL of the questions in Part 2, proceed to Part 3.

Part 3 – Rate qualification	Applicant 1	Applicant 2
1. In the last **two (2) years**, have you smoked or used any tobacco products?	❑ Yes ❑ No	❑ Yes ❑ No

If you answered **"YES"** to the question in Part 3, you qualify for Rate Category A. If you answered **"NO"** to the question in Part 3, you qualify for Rate Category A+.

PLEASE READ CAREFULLY BEFORE SIGNING - I apply to The Manufacturers Life Insurance Company (Manulife Financial) for insurance under the Medicare International Travel Insurance policy administered by 21st Century Travel Insurance Limited. I declare that all the information I have provided on this application form and medical questionnaire (if required) is true and complete. I have read the Medicare International Travel Insurance policy and understand the terms, conditions and exclusions (including the pre-existing condition exclusion) that apply to my coverage. I understand that if I misrepresent any material information provided in this application, Manulife Financial will void my policy and I will not be covered for any benefits under this policy. I authorize any hospital, physician, other medical service provider or any other organization or person that has any records or knowledge of me or my health to release to World Travel Protection Inc. and/or Manulife Financial and its reinsurers and/or 21st Century Travel Insurance Limited, any such information for the purpose of this application and contract and any subsequent claim.

Applicant 1 Signature: _____ **Applicant 2 Signature:** _____ **Date:** _____

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