



Please send your completed application and your cheque payable to:

Ingle International & Imagine Financial Ltd.
460 Richmond Street West, Suite 100
Toronto, Ontario M5V 1Y1

For more information, call 1-800-360-3234 or 416-730-8488
or visit Ingle online at www.ingleinternational.com

For Broker/Sales Agent Use Only			10 26 APM ECA 0817 000
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

Applicant 1				Date of Birth (D/M/Y) ____/____/____
	First Name	Last Name		<input type="checkbox"/> Male <input type="checkbox"/> Female
Applicant 2				Date of Birth (D/M/Y) ____/____/____
	First Name	Last Name		<input type="checkbox"/> Male <input type="checkbox"/> 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.

1. **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.
2. **Metastatic cancer:** means a cancer that has spread from its original site to one or more other area(s) of the body.
3. **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.
4. **Stable:** means any medical condition (other than a *minor ailment*) 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 results of further investigations for that medical condition.
5. **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 any complication of a chronic condition is not considered a minor ailment.
6. **Regular check-up:** means any periodic medical examination, unrelated to any specific medical condition or symptom, which is intended to verify *your* general state of health.

IMPORTANT NOTICE

Important Notice About Your Health Changes: If your health changes or does not remain *stable* between the date you complete and submit this Medical Questionnaire and your effective date, you must review the medical questions with your broker or sales agent. If you are no longer eligible, or no longer qualify 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).

Important Notice About Your Personal Information: By submitting this application you agree that Royal & Sun Alliance Insurance Company of Canada (“we”, “us”) may collect, use and disclose your Personal Information (including to and from your broker, our affiliates and service providers and organizations that may have referred you to us, and professional associations of which you may be a member) for purposes of quoting a premium, policy administration, improving customer experience, administering referral arrangements, and for other lawful purposes described in our Protecting Customer Privacy document. For a copy of this document please see www.rsatravelinsurance.com.

**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?

1. Please confirm your eligibility to apply for this insurance.

You must meet the following criteria to be eligible for this insurance:

- You must be a Canadian resident and be covered by the government health insurance plan (GHIP) of your Canadian province or territory of residence for the entire duration of your trip.
- You must NOT be travelling against the advice of a physician or have been diagnosed with a **Terminal illness** or **Metastatic cancer**.
- You must NOT have a **Kidney disease** requiring dialysis.
- You must NOT have been prescribed or used **home oxygen** during the 12 months prior to your date of application.
- You must be at least 15 days old.

Additionally, if you are applying for the Non-Medical Single Trip Plan or Non-Medical Multi-Trip Annual Plan:

This insurance must be:

- a) Issued in Canada for travel arrangements booked through a supplier of travel services; and
- b) Purchased prior to the contracted date of departure from your home province or territory of residence or Canada.

Note: For Trip Cancellation benefits to apply to your covered trip, coverage must be in effect within 7 days of the initial deposit for your covered trip or prior to any cancellation penalties being applicable for your covered trip.

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

If you are eligible and are applying for the Canada Plan, 60 to 79 Vacation Plan, Non-Medical Single Trip Plan, Non-Medical Multi-Trip Annual Plan or 40-Day Supplemental Multi-Trip Annual Plan for PSHCP members, you may proceed directly to Section I. If you are eligible and applying for any other plan, please continue to section D.

D – Do you require customized Medical Underwriting?

2. Have you had **Heart bypass surgery** or **Heart angioplasty** (including stent placement) more than 12 years ago?

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

3. 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
--	--

4. Do you have a surgically unrepaired **Aneurysm** of 4.0 cm or more?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
--	--

5. In the past 5 years, have you been diagnosed with or *treated* for **Congestive heart failure** or **Cardiomyopathy** 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
--	--

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

E – Do you use tobacco products?

6. In the past 5 years, have you smoked or used any tobacco products?

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

If you have answered YES to Question 6, a 20% surcharge will apply to your premium. Please continue to Section F.

F – Which plan do you qualify for?

PART 1 – ADVANTAGE OR STANDARD?

7. In the past 10 years, have you been diagnosed with or *treated* for any **Heart condition** or do you currently have a cardiac stent, shunt, pacemaker and/or defibrillator?

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

8. In the past 5 years, have you been diagnosed with or *treated* for:

a) **Diabetes** or **Glucose intolerance** (pre-diabetes)?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
--	--

b) **Stroke** or **Mini-stroke** (CVA/TIA)?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
--	--

c) **Peripheral Vascular Disease** (PVD), **Carotid Artery Stenosis** or any narrowed or blocked artery, excluding coronary artery disease?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
--	--

d) **Lung condition** (such as any prescription for puffers/inhalers), excluding lung cancer, pulmonary embolism or a *minor ailment*?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
--	--

e) **Dementia** or **Alzheimer’s disease**?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
--	--

f) **Cancer** (excluding basal or squamous cell skin cancer)?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
--	--

F – Which plan do you qualify for? (Continued)

	Applicant 1	Applicant 2
9. In the past 2 years, have you been diagnosed with or treated for any of the following: • Crohn's disease or Ulcerative colitis ? • Gastrointestinal bleeding, Bowel obstruction or have had Bowel surgery ? • Kidney disease (including stones), excluding kidney cancer? • Liver disease , excluding liver cancer? • Gallbladder disease (including stones), excluding gallbladder cancer? Not applicable if your gallbladder has been removed. • Pancreatitis ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you have answered NO to ALL questions in Part 1, please continue to Part 2. If you have answered YES to ONLY 1 question in Part 1, you qualify for Advantage. If you have answered YES to 2 OR MORE questions in Part 1, you qualify for Standard. Please continue to Section G.		

PART 2 – SUPREME OR ELITE?

10. Has it been more than 24 months since your last regular check-up with a physician or a licensed nurse practitioner?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. In the past 12 months, have you been diagnosed with or <i>treated</i> for:		
a) High blood pressure ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) High cholesterol ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you have answered NO to ALL questions in Part 2, you qualify for Supreme. If you have answered YES to ANY question in Part 2, you qualify for Elite. Please continue to Section G.		

G – Qualification Table

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

You Qualify for	Stability Period	Applicant 1	Applicant 2
Supreme	90 days	<input type="checkbox"/>	<input type="checkbox"/>
Elite	90 days	<input type="checkbox"/>	<input type="checkbox"/>
Advantage	365 days	<input type="checkbox"/>	<input type="checkbox"/>
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 Stability Period prior to each departure date.
- Your heart condition, if **any** heart condition was not *stable* at any time during the applicable Stability 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 Stability Period prior to each departure date.

H – 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 F**, will be subject to the Pre-Existing Medical Condition Exclusions. I will refer to my policy 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 answer to any question is related to the cause of my claim or would have rendered me ineligible or resulted solely in a higher applicable premium. 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 to obtain 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. If it is not reasonably possible for you to contact Global Excel before seeking treatment due to the nature of your emergency, you must have

someone else call on your behalf or you must call as soon as medically possible. Failure to do so limits benefits payable to you:

- In the event of hospitalization, 80% of eligible expenses, based on reasonable and customary costs, to a maximum of \$25,000; and
- In the event of an outpatient medical consultation, a maximum of one visit per sickness or injury. You will be responsible for payment of any remaining charges.
- Medical Authorization in Case of a Claim – I understand that the insurer 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 its authorized administrator, 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)

I - Trip Information

Check the applicable Plan and Qualification you are applying for.

Applicant 1

PLANS

EMERGENCY MEDICAL TRAVEL INSURANCE PLANS

- Medical Multi-Trip Annual Plan: 4-Day 9-Day 16-Day 30-Day*
 40-Day Supplemental for PSHCP members

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

- Medical Single Trip Daily Plan 60 to 79 Vacation Plan Canada Plan
 Departure Date (D/M/Y): ___/___/___ Return Date (D/M/Y): ___/___/___

NON-MEDICAL TRAVEL INSURANCE PLANS

- Non-Medical Multi-Trip Annual Plan: 4-Day 9-Day 16-Day 30-Day*

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

- Non-Medical Single Trip Plan Trip Value: \$ _____
 Departure Date (D/M/Y): ___/___/___ Return Date (D/M/Y): ___/___/___

TOP UP

- Medical Single Trip Daily Plan – Top Up Non-Medical Single Trip Top Up Plan**

Departure Date (D/M/Y): ___/___/___ Number of Pre-insured days: _____

Top Up Effective Date*** (D/M/Y): ___/___/___ Return Date (D/M/Y): ___/___/___

Name of the other Insurer (if applicable): _____

- * The 30-day Multi-Trip Annual Plan option is only available to age 79 or under.
 ** The Non-Medical Single Trip Top Up Plan does not include Trip Cancellation benefits.
 *** The Top Up Effective Date will be the day after your existing coverage terminates.

QUALIFICATION (For Medical Questionnaire Applicants only)

- Supreme Elite 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%)

TOBACCO USER (For Medical Questionnaire Applicants only)

During the 5 years prior to your application, have you smoked or used any tobacco products? Yes No

Applicant 2

PLANS

EMERGENCY MEDICAL TRAVEL INSURANCE PLANS

- Medical Multi-Trip Annual Plan: 4-Day 9-Day 16-Day 30-Day*
 40-Day Supplemental for PSHCP members

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

- Medical Single Trip Daily Plan 60 to 79 Vacation Plan Canada Plan
 Departure Date (D/M/Y): ___/___/___ Return Date (D/M/Y): ___/___/___

NON-MEDICAL TRAVEL INSURANCE PLANS

- Non-Medical Multi-Trip Annual Plan: 4-Day 9-Day 16-Day 30-Day*

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

- Non-Medical Single Trip Plan Trip Value: \$ _____
 Departure Date (D/M/Y): ___/___/___ Return Date (D/M/Y): ___/___/___

TOP UP

- Medical Single Trip Daily Plan – Top Up Non-Medical Single Trip Top Up Plan**

Departure Date (D/M/Y): ___/___/___ Number of Pre-insured days: _____

Top Up Effective Date*** (D/M/Y): ___/___/___ Return Date (D/M/Y): ___/___/___

Name of the other Insurer (if applicable): _____

- * The 30-day Multi-Trip Annual Plan option is only available to age 79 or under.
 ** The Non-Medical Single Trip Top Up Plan does not include Trip Cancellation benefits.
 *** The Top Up Effective Date will be the day after your existing coverage terminates.

QUALIFICATION (For Medical Questionnaire Applicants only)

- Supreme Elite 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%)

TOBACCO USER (For Medical Questionnaire Applicants only)

During the 5 years prior to your application, have you smoked or used any tobacco products? Yes No

J - Premium and Payment

Please complete the Premium Calculation page to determine each Applicant's total premium. For rates to top up the Non-Medical Multi-Trip Annual Plan, contact your broker or sales agent.

If you are applying for the Canada Plan, 60 to 79 Vacation Plan, Non-Medical Single Trip Plan, Non-Medical Multi-Trip Annual Plan or 40-Day Supplemental Multi-Trip Annual Plan for PSHCP members, 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

Method of Payment

- Visa MasterCard AMEX Cheque made payable to the broker or sales agent indicated on the front of this application

Credit Card Information

Card Number

Expiry Date (M/Y)



Name of Cardholder

Signature of Cardholder

Date Signed (D/M/Y)