

Age 55 or over
Effective August 25, 2008

CALL 1-800-238-8284, one of our representatives will be happy to assist you.



Authorized Broker:

Agency Code
1912

Broker Code

FOR BROKER/SALES AGENT USE ONLY			
APPLICANT 1		APPLICANT 2	10 12 APM ECA 0808 000
Policy Number: <input style="width: 80%;" type="text"/>	Date issued (D/M/Y): <input style="width: 80%;" type="text"/>	Policy Number: <input style="width: 80%;" type="text"/>	Date issued (D/M/Y): <input style="width: 80%;" type="text"/>

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.royalsunalliance.ca, or call us at 1-800-716-4339.

APPLICANT 1	APPLICANT 2
Last Name (Maiden for Quebec only) <input style="width: 80%;" type="text"/> First Name <input style="width: 80%;" type="text"/> Date of Birth (Day/Month/Year) <input style="width: 80%;" type="text"/>	Last Name (Maiden for Quebec only) <input style="width: 80%;" type="text"/> First Name <input style="width: 80%;" type="text"/> Date of Birth (Day/Month/Year) <input style="width: 80%;" type="text"/>
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female

HOME ADDRESS:

Street: <input style="width: 95%;" type="text"/>	City: <input style="width: 95%;" type="text"/>	Province: <input style="width: 95%;" type="text"/>
Postal Code: <input style="width: 80%;" type="text"/>	E-mail: <input style="width: 80%;" type="text"/>	Tel.: () <input style="width: 80%;" type="text"/>

DESTINATION ADDRESS:

Street: <input style="width: 95%;" type="text"/>	City: <input style="width: 95%;" type="text"/>	Province/State: <input style="width: 95%;" type="text"/>
Postal/Zip Code: <input style="width: 80%;" type="text"/>	E-mail: <input style="width: 80%;" type="text"/>	Tel.: () <input style="width: 80%;" type="text"/>
Emergency Contact Name: <input style="width: 95%;" type="text"/>		Tel.: () <input style="width: 80%;" type="text"/>

DEFINITIONS

Please refer to the following definitions for the words TREATED, STABLE and MINOR AILMENT. These words appear throughout this application with the reference notations 1 through 3.

1. **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.
2. **Stable** means any medical condition (other than a minor ailment¹) 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.
3. **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.

PLAN INFORMATION

In addition to the Single Trip Daily and Multi-Trip Annual Plans, Medi-Select Advantage also offers the following plans. Complete Part A. No signature is required:

- **CANADA PLAN:** Available only if you are travelling outside your province or territory of residence but within Canada, for the entire duration of your trip. No pre-existing medical condition exclusions apply for this plan.
- **55 TO 74 VACATION PLAN:** Available only if you are between ages 55 and 74 and are travelling outside your province or territory of residence for a maximum of 15 days. Please note that this plan does not cover

pre-existing medical conditions that were not stable² at any time during the **90 days** prior to each departure date. Please refer to the pre-existing medical condition exclusions 1, 2 and 3 on page 3.

- **40-DAY SUPPLEMENTAL MULTI-TRIP ANNUAL PLAN FOR PSHCP MEMBERS:** Increase your coverage from \$500,000 to \$5 million and be covered for Trip Cancellation, Interruption and Delay benefits up to \$4,000. Also be covered for benefits not offered by the PSHCP, such as Vehicle Return or Emergency Relief of Dental Pain from the first dollar. See your policy for the full pre-existing medical condition exclusions.

INSTRUCTIONS

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.

STEP 1: Complete the Personal Information section above.

If you are applying for the 40-day Supplemental Multi-Trip Annual Plan for PSHCP members, please proceed to STEP 5.

STEP 2: Complete PART A, Eligibility Criteria on page 2.

If you are eligible for this insurance and are applying for the Canada Plan or the 55 to 74 Vacation Plan, please proceed to STEP 5. No signature is required for these plans.

STEP 3: Complete PART B - Plan Eligibility and PART C - Plan Qualification by checking off either YES or NO to each question until your plan eligibility and qualification has been determined.

Note: 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 the application.

STEP 4: Check off the plan for which you qualify, in PART D. Be sure to read, understand and sign the Agreement, Understanding and Authorization section.

STEP 5: Complete the Trip Information, Premium Calculation and Method of Payment sections on Page 4 and return your application to the address provided above.

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.

PART A ELIGIBILITY CRITERIA

IMPORTANT: If you must answer **YES** to any question in **PART A**, you are **NOT ELIGIBLE** to purchase this insurance.

This travel insurance is only available to you if you are a Canadian resident and you are covered by the government health insurance plan of your province or territory of residence for the entire duration of your trip and you answer **NO** to questions 1 to 4 below.

	APPLICANT 1		APPLICANT 2	
	YES	NO	YES	NO
1. Are you travelling against the advice of a physician or have you been diagnosed with a terminal illness or metastatic cancer? 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have a kidney disease requiring dialysis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. During the 12 months prior to your departure date, have you been prescribed or used home oxygen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever been diagnosed with AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART B PLAN ELIGIBILITY

IMPORTANT: If you must answer **YES** to any questions in **PART B**, you are **NOT ELIGIBLE** to purchase this insurance. Other insurance coverage options may be available. Please consult your broker or sales agent. If you have answered **NO** to all of the questions, please continue to Part C - Plan Qualification below.

	APPLICANT 1		APPLICANT 2	
	YES	NO	YES	NO
5. Have you had:				
a) heart bypass surgery more than 10 years prior to your departure date? (Use the date of your most recent bypass)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) heart angioplasty more than 10 years prior to your departure date? (Use the date of your most recent angioplasty)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had an organ transplant (excluding corneal transplant)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you been diagnosed with or treated ¹ for congestive heart failure in the last 5 years or are you currently taking Lasix or furosemide?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. During the 5 years prior to your departure date, have you been diagnosed with or treated for water on your lungs or ankle/leg swelling for which you have taken Lasix or furosemide or a water pill (excluding a water pill taken for high blood pressure)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. During the 12 months prior to your departure date, have you:				
a) been diagnosed with or been hospitalized for a new heart condition, or had an existing heart condition which required hospitalization or a change in medication (refer to Definitions, Stable, 2b)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) had a lung condition (including pneumonia) which required hospitalization or treatment with prednisone (Deltasone or other generics)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) had a diagnosis of or been treated ¹ for a total of 3 or more of the following medical conditions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Heart condition (including a pacemaker)				
• Stroke (CVA) or mini-stroke (TIA)				
• High blood pressure/hypertension				
• Peripheral vascular disease or Carotid Artery Stenosis (blocked or clogged arteries in the legs or neck)				
• Lung condition (including any prescription for puffers/inhalers) excluding a minor ailment ²				
• Diabetes (treated with oral medication or insulin)				
• Dementia/Alzheimer's disease				

PART C PLAN QUALIFICATION

	APPLICANT 1		APPLICANT 2	
	YES	NO	YES	NO
SECTION 1				
10. During the 5 years prior to your departure date, have you smoked cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IMPORTANT!	Please proceed to Section 2.			
SECTION 2				
11. During the 10 years prior to your departure date, have you been diagnosed with or treated ¹ for a heart condition (including pacemaker)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. During the 5 years prior to your departure date, have you been diagnosed with or treated ¹ for any of the following medical conditions:				
a) Lung condition (including any prescription for puffers/inhalers) excluding a minor ailment ² ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Stroke (CVA)/ mini-stroke (TIA)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Diabetes (treated with oral medication or insulin)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Peripheral vascular disease or Carotid Artery Stenosis (blocked or clogged arteries in the legs or neck)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Dementia/Alzheimer's disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. During the 5 years prior to your departure date, have you been diagnosed with or treated ¹ for both high blood pressure AND high cholesterol in addition to any other condition listed in section 2?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IMPORTANT!	If you must answer YES to two or more questions in Section 2, you qualify for the Standard Plan. If you must answer YES to only ONE question in Section 2, you qualify for the Advantage Plan. Please proceed to Part D. If you answer NO to all the questions in Section 2, please proceed to Section 3.			
SECTION 3				
14. During the 2 years prior to your departure date, have you been diagnosed with or treated ¹ for any of the following medical conditions:				
a) Cancer (excluding basal or squamous cell skin cancer or breast cancer treated only with Tamoxifen, Femara or Arimidex)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Diabetes (treated only with diet) or impaired glucose intolerance (pre-diabetes)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Chronic bowel disease (such as but not limited to: Crohn's disease, ulcerative colitis)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Gastrointestinal bleeding, bowel obstruction or bowel surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Gallbladder disease (including stones)? If your gallbladder has been removed, answer NO.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Liver disease, pancreatitis or kidney disease (including stones)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Aneurysm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IMPORTANT!	If you must answer YES to any question in Section 3, you qualify for the Preferred Plan. Please proceed to Part D. If you answer NO to all the questions in Section 3, please proceed to Section 4.			

PART C PLAN QUALIFICATION (continued)

SECTION 4		APPLICANT 1		APPLICANT 2	
		YES	NO	YES	NO
	15. Have you ever been diagnosed with or treated ¹ for any of the following conditions: • heart condition (excluding extra beats or palpitations for which you have not been treated ¹) • lung condition (including any prescription for puffers/inhalers) excluding a minor ailment ³ • stroke (CVA) or mini-stroke (TIA)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	16. During the 12 months prior to your departure date, have you been diagnosed with or treated ¹ for high blood pressure/hypertension?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	17. Has it been more than 18 months since your last regular check-up with a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IMPORTANT!

If you must answer YES to any question in Section 1 and/or Section 4, you qualify for the Elite Plan. If you answer NO to all the questions in Sections 1, 2, 3 and 4 you qualify for the Supreme Plan. Note: If you qualify for the Supreme Plan, you may select either the Supreme Plan or the Elite Plan.

PART D

PLEASE INDICATE THE PLAN FOR WHICH YOU QUALIFY AND READ THE PRE-EXISTING MEDICAL CONDITION EXCLUSIONS.

PLAN QUALIFICATION TABLE				
IF YOU QUALIFY FOR:	PRE-EXISTING PERIOD	PRE-EXISTING MEDICAL CONDITION EXCLUSIONS	APPLICANT 1	APPLICANT 2
SUPREME	90 days	4	<input type="checkbox"/>	<input type="checkbox"/>
ELITE	90 days	1, 2, 3	<input type="checkbox"/>	<input type="checkbox"/>
PREFERRED	90 days	1, 2, 3	<input type="checkbox"/>	<input type="checkbox"/>
ADVANTAGE*	365 days (90 days for high blood pressure/hypertension and 180 days for cancer)	1, 2, 3	<input type="checkbox"/>	<input type="checkbox"/>
STANDARD*	365 days (90 days for high blood pressure/hypertension and 180 days for cancer)	1, 2, 3	<input type="checkbox"/>	<input type="checkbox"/>
* Note: If you qualify for the Advantage or the Standard Plan, you may choose Advantage Option or Standard Option to benefit from a 180-day stability period instead of a 365-day period.				
ADVANTAGE OPTION	180 days (90 days for high blood pressure/hypertension)	1, 2, 3	<input type="checkbox"/>	<input type="checkbox"/>
STANDARD OPTION			<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 ailment³) that was not stable² at any time during the applicable Pre-existing Period prior to each departure date.
- Your heart condition, if any heart condition was not stable² at any time during the applicable Pre-existing Period prior to each departure date.
- Your lung condition, if:
 - any lung condition was not stable²; 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 Pre-existing Period prior to each departure date.
- Any sickness, injury or medical condition (other than a minor ailment³) for which you were hospitalized, have been prescribed (including prescribed as needed), have taken medication or have undergone a medical or surgical procedure at any time during the applicable Pre-existing Period prior to each departure date.

IMPORTANT NOTICE: If your health changes or does not remain stable² between the date you complete and submit the application and your departure date, you must review the medical questions in this application 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. If you are purchasing a Multi-Trip Annual Plan and your health changes or does not remain stable² after the date you choose for coverage to begin, 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 **PART C**, will be subject to the pre-existing medical condition exclusion(s) of the plan I qualify for. I will refer to my policy and to the above for the full pre-existing medical condition exclusion clause.
- I personally provided the answers on this application and all information disclosed is true and accurate. The Insurer will, in the event of any sickness or injury, review my prior medical history and my answers. I fully understand that if any of my answers are inaccurate, in the event of a claim, the Insurer will void my policy and my claim will be refused. I understand that the answers on my application are relevant to the risk and constitute the basis of my insurance. Where I was unsure of my medical history as it relates to the medical questions, I have verified it with my physician.

- 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.

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

APPLICANT 2

PLAN TYPE

Multi-Trip Annual Plan

- 9 days 16 days 30 days
- 60 days 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

Effective Date: D M Y

Expiry Date: D M Y

Deductible Options (US\$)

- \$0 \$250 \$500 \$1,000 \$5,000 \$10,000

PLAN TYPE

Multi-Trip Annual Plan

- 9 days 16 days 30 days
- 60 days 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

Effective Date: D M Y

Expiry Date: D M Y

Deductible Options (US\$)

- \$0 \$250 \$500 \$1,000 \$5,000 \$10,000

Note: Deductible Options do not apply to the 40-day Supplemental Multi-Trip Annual Plan for PSHCP members, Canada Plan or 55-74 Vacation 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 below the name of the other insurer as well as the number of insured days.

Name of the other insurer: _____ Number of days: _____

PREMIUM CALCULATION and METHOD OF PAYMENT

APPLICANT 1

APPLICANT 2

PLEASE REFER TO THE RATE SHEET FOR THE SINGLE TRIP PREMIUM CALCULATION INSTRUCTIONS

1. Multi-Trip Annual Premium*	\$ _____	\$ _____
2. If you have smoked cigarettes during the 5 years prior to your effective date, add 15% to your <u>Multi-Trip Annual</u> premium	\$ _____	\$ _____
3. For the All-Inclusive Multi-Trip Annual Plan, add the applicable sales tax (Ontario 8%, Québec 9%)	\$ _____	\$ _____
4. Single Trip Daily Premium (including the Canada Plan and the 55 to 74 Vacation Plan)		
a) Total trip duration	a) _____ days	a) _____ days
b) Existing coverage, if applicable	b) _____ days	b) _____ days
c) Travel days covered by Single Trip Daily Plan	c) = _____ days	c) = _____ days
d) Single Trip Daily Plan rate* based on total trip duration	d) \$ _____ c x d = \$ _____	d) \$ _____ c x d = \$ _____
5. If you have smoked cigarettes during the 5 years prior to your departure date, add 15% to your <u>Single Trip Daily Plan</u> rate (not applicable to the Canada Plan or the 55 to 74 Vacation Plan)	\$ _____	\$ _____
6. Subtotal of lines 3 to 5	\$ _____	\$ _____
7. Deductible Options: (add or subtract % - refer to the rate sheet) \$ _____ US	\$ _____	\$ _____
8. Subtotal of lines 6 and 7	\$ _____	\$ _____
9. Travel Companion Discount: 5% of line 8 for each applicant (if applicable, refer to the rate sheet)	\$ _____	\$ _____
10. Subtract line 9 from line 8	\$ _____	\$ _____
11. Travel Insurance Premium (Subtotal of lines 1 to 10. The minimum premium is \$25 per person)	\$ _____	\$ _____
12. Top Up Surcharge: Add \$25 if you are topping up another carrier's coverage	\$ _____	\$ _____
13. TOTAL TRAVEL INSURANCE PREMIUM (line 11 + line 12)		\$ _____

TOTAL PAYMENT SUBMITTED FOR APPLICANT 1 AND APPLICANT 2 \$ _____

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)



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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