



Age 55 or over
Effective August 10, 2009

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

Agency Code 1912
Broker Code



Authorized Broker: [Empty box]

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FOR BROKER/SALES AGENT USE ONLY
APPLICANT 1 APPLICANT 2
Policy Number: Date issued (D/M/Y):

APPLICATION INFORMATION

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.
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 this Application.
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.

If you are applying for:
• a Multi-Trip Annual Plan or a Single Trip Daily Plan, complete all parts of this Application.
• the Canada Plan, the Vacation Plan (age 55 to 74) or the 40-Day Supplemental Multi-Trip Annual Plan for PSHCP Members, review and complete only the Eligibility Criteria on page 2. If you are eligible, turn to page 4 and complete the Trip Information and Premium Calculation sections.

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

APPLICANT 1 APPLICANT 2
Last Name (Maiden Name for Quebec only) First Name
Date of Birth (Day/Month/Year) Male Female

HOME ADDRESS: DESTINATION ADDRESS:
Street: City: Province:
Postal Code: E-mail: Tel.: ()
Emergency Contact Name: Tel.: ()

DEFINITIONS
The following words appear throughout this application with the reference notations 1 through 4. Please refer to them as they are important definitions.

- 1. 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.
2. Regular check-up: means any standard or customary medical examination unrelated to any specific medical condition and which is carried out for the purpose of screening, health monitoring or preventive care and may include routine medical tests and investigations.
3. 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.
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.
4. 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.



ELIGIBILITY CRITERIA

This insurance is only available if you are a **Canadian resident** covered by the Government Health Insurance Plan in your province or territory of residence for the **entire duration of your trip**.

	APPLICANT 1		APPLICANT 2	
	YES	NO	YES	NO
1. Are you:				
a) Travelling against the advice of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been diagnosed with:				
a) A Terminal illness ? 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"/>
b) Metastatic cancer ? Metastatic cancer means a cancer that has spread from its original site to one or more other area(s) of the body.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. During the 12 months prior to the date of your application, have you been prescribed or used:				
a) Home oxygen ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have:				
a) A Kidney disease requiring dialysis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• If you answered **NO** to **ALL** questions in **ELIGIBILITY CRITERIA**, please proceed to **PLAN ELIGIBILITY** below.
 • If you have a **YES** answer to **ANY** question in **ELIGIBILITY CRITERIA**, you are **NOT ELIGIBLE** to purchase this insurance.

PLAN ELIGIBILITY

	APPLICANT 1		APPLICANT 2	
	YES	NO	YES	NO
5. Have you ever had:				
a) A Bone marrow transplant or an Organ transplant (excluding corneal transplant)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has it been more than 10 years from the date of your application since you had:				
a) Heart bypass surgery (use the date of the most recent bypass)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Heart angioplasty , including stent placement (use the date of the most recent angioplasty)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. During the 5 years prior to the date of your application, have you been diagnosed with or treated⁴ for:				
a) Congestive heart failure or are you currently taking Lasix or Furosemide ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Water on lungs or ankle or leg swelling for which you have taken Lasix , 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"/>
8. During the 12 months prior to the date of your application, have you been diagnosed with or been hospitalized for:				
a) A new Heart condition , or had an existing Heart condition which required hospitalization or a change in medication? (refer to DEFINITIONS 3. stable (b))	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. During the 12 months prior to the date of your application, have you had:				
a) 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"/>
10. During the 12 months prior to the date of your application, have you been diagnosed with or treated⁴ for 3 or more of the following medical conditions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> • Heart condition (including pacemaker)? • Stroke (CVA) or mini-stroke (TIA)? • High blood pressure? • Dementia or Alzheimer's disease? • Lung condition (including any prescription for puffers/inhalers) excluding a minor ailment¹? • Diabetes (treated with oral medication or insulin)? • Peripheral vascular disease (PVD: narrowing or blockage of any blood vessel)? 				
11. Do you have:				
a) An Aneurysm of 3.5 cm or more which remains surgically untreated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• If you answered **NO** to **ALL** questions in **PLAN ELIGIBILITY**, please proceed to **PLAN QUALIFICATION** below.
 • If you have a **YES** answer to **ANY** question in **PLAN ELIGIBILITY**, you are **NOT ELIGIBLE** to purchase this insurance. Other insurance coverage options may be available; please contact your broker or sales agent.

PLAN QUALIFICATION

PART A

	PART A		PART A	
	YES	NO	YES	NO
12. During the 5 years prior to the date of your application, have you:				
a) Smoked cigarettes ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART B

	PART B		PART B	
	YES	NO	YES	NO
13. During the 10 years prior to the date of your application, have you been diagnosed with or treated⁴ for:				
a) A Heart condition (including pacemaker)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. During the 5 years prior to the date of your application, have you been diagnosed with or treated⁴ for any of the following medical conditions:				
a) Stroke (CVA) or mini-stroke (TIA)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Diabetes (treated with oral medication or insulin)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Peripheral vascular disease (PVD: narrowing or blockage of any blood vessel)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Both High blood pressure and high cholesterol , only if you answered YES to any of the medical conditions listed in questions 13 a), 14 a), 14 b) or 14 c)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Lung condition (including any prescription for puffers/inhalers) excluding a minor ailment ¹ ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Dementia or Alzheimer's disease ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) 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"/>

PART B (continued)

PART B

		YES	NO	YES	NO
15. During the 2 years prior to the date of your application, have you been diagnosed with or treated⁴ for any of the following medical conditions :					
a)	Chronic bowel disease (such as but not limited to Crohn's disease or Ulcerative colitis)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b)	Gastrointestinal bleeding, bowel obstruction or have you had bowel surgery ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c)	Gallbladder disease (such as stones)? If your gallbladder has been removed, answer NO.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d)	Liver disease ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e)	Pancreatitis ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f)	Kidney disease (including stones)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g)	Diabetes (treated only with diet) or glucose intolerance (pre-diabetes)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- If you answered **NO** to **ALL** questions in **PART B**, please proceed to **PART C** below.
- If you have **1 YES** answer in **PART B**, you qualify for **ADVANTAGE**. Please skip the remaining questions **and** proceed to the **QUALIFICATION TABLE**.
- If you have **2 or more YES** answers in **PART B**, you qualify for **STANDARD**. Please skip the remaining questions **and** proceed to the **QUALIFICATION TABLE**.

PART C

PART C

		YES	NO	YES	NO
16. Have you ever been diagnosed with or treated⁴ for any of the following medical conditions :					
	• Heart condition (excluding extra beats or palpitations for which you have not been treated ⁴)? • Stroke (CVA) or mini-stroke (TIA) ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	• Lung condition (including any prescription for puffers/inhalers) excluding a minor ailment ¹ ?				
17. Has it been more than 18 months since you had a :					
a)	Regular check-up² with a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. During the 12 months prior to the date of your application, have you been diagnosed with or treated⁴ for:					
a)	High blood pressure ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b)	Any medical condition excluding a minor ailment ¹ not specifically mentioned in this Application ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- If you answered **NO** to **ALL** questions in **PARTS A, B, and C**, you qualify for **SUPREME**. Please proceed to the **QUALIFICATION TABLE**.
- If you answered **YES** to the question in **PART A** **and NO** to **ALL** questions in **PARTS B and C**, you qualify for **ELITE**. Please proceed to the **QUALIFICATION TABLE**.
- If you answered **YES or NO** to the question in **PART A** **and** you have **1 YES** answer in **PART C**, you qualify for **ELITE**. Please proceed to the **QUALIFICATION TABLE**.
- If you answered **YES or NO** to the question in **PART A** **and** you have **2 or more YES** answers in **PART C**, you qualify for **PREFERRED**. Please proceed to the **QUALIFICATION TABLE**.

QUALIFICATION TABLE

PLEASE INDICATE YOUR QUALIFICATION AND READ THE PRE-EXISTING MEDICAL CONDITION EXCLUSIONS.

IF YOU QUALIFY FOR:	PRE-EXISTING PERIOD	PRE-EXISTING MEDICAL CONDITION EXCLUSIONS	APPLICANT 1	APPLICANT 2
SUPREME	90 days	1, 2, 3	<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	1, 2, 3	<input type="checkbox"/>	<input type="checkbox"/>
STANDARD	365 days	1, 2, 3	<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 ailment¹) that was not stable³ at any time during the applicable Pre-existing Period prior to each departure date.
- Your heart condition, if any heart condition was not stable³ at any time during the applicable Pre-existing Period prior to each departure date.
- Your lung condition, if:
 - any lung condition was not stable³; 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.

IMPORTANT NOTICE: If your health changes or does not remain stable³ between the date you complete and submit this Application and your departure date, you must review the medical questions 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. However, if you are purchasing a Multi-Trip Annual Plan and your health changes or does not remain stable³ after the effective date, 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 the **Plan Qualification**, will be subject to the pre-existing medical condition exclusions as stated above. I will refer to my policy and to the above 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 Application 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 question is related to the cause of my claim. I understand that the answers on my Application are relevant to the risk and constitute the basis of my insurance.

- 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.
- I understand that some exclusions may apply and affect my coverage. I will read my insurance policy for additional details.

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		PLAN TYPE
Multi-Trip Annual Plan <input type="checkbox"/> 9 days <input type="checkbox"/> 16 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days Effective Date (D/M/Y): <input style="width: 100px;" type="text"/> <input type="checkbox"/> 40-day PSHCP Supplemental Effective Date (D/M/Y): <input style="width: 100px;" type="text"/> All-Inclusive Multi-Trip Annual Plan <input type="checkbox"/> 9 days <input type="checkbox"/> 16 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days Effective Date (D/M/Y): <input style="width: 100px;" type="text"/> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> Deductible Options (US\$) <input type="checkbox"/> \$0 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 </div>	Single Trip Daily Plan <input type="checkbox"/> Single Trip with Medical Declaration <input type="checkbox"/> Canada Plan <input type="checkbox"/> 55 to 74 Vacation Plan Departure Date (D/M/Y): <input style="width: 100px;" type="text"/> * Effective Date (D/M/Y): <input style="width: 100px;" type="text"/> Expiry Date (D/M/Y): <input style="width: 100px;" type="text"/> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> Deductible Options (US\$) <input type="checkbox"/> \$0 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 </div>	Multi-Trip Annual Plan <input type="checkbox"/> 9 days <input type="checkbox"/> 16 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days Effective Date (D/M/Y): <input style="width: 100px;" type="text"/> <input type="checkbox"/> 40-day PSHCP Supplemental Effective Date (D/M/Y): <input style="width: 100px;" type="text"/> All-Inclusive Multi-Trip Annual Plan <input type="checkbox"/> 9 days <input type="checkbox"/> 16 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days Effective Date (D/M/Y): <input style="width: 100px;" type="text"/> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> Deductible Options (US\$) <input type="checkbox"/> \$0 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 </div>

Note: Deductible Options apply only to the Multi-Trip Annual Plan and the Single Trip with Medical Declaration 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 the name of the other insurer: _____ and the number of insured days _____.

PREMIUM CALCULATION and METHOD OF PAYMENT	APPLICANT 1	APPLICANT 2
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PLEASE REFER TO THE RATE SHEET FOR THE PREMIUMS

1. Multi-Trip Annual Premium

a) Your premium from the respective rate table: <i>located on your rate sheet</i>	a) \$ _____	a) \$ _____
b) If you have smoked cigarettes during the 5 years prior to your effective date, add 20% of your premium: <i>1.2 x line a</i>	b) \$ _____	b) \$ _____
c) For the <u>All-Inclusive Multi-Trip Annual Plan</u> , calculate the appropriate tax portion based on line b) (Ontario 8%, Quebec 9%): <i>Tax x line b</i>	c) \$ _____	c) \$ _____
d) Multi-Trip Annual Subtotal: <i>line b) + line c)</i>	\$ _____	\$ _____

2. Single Trip Daily and/or Top Up

a) Total trip duration	a) _____ days	a) _____ days
b) Existing coverage, if applicable.....	b) _____ days	b) _____ days
c) Travel days covered by a Single Trip Daily Plan: <i>line a) – line b)</i>	c) _____ days	c) _____ days
d) Single Trip Daily Plan rate based on total trip duration: <i>located on your rate sheet</i>	d) \$ _____	d) \$ _____
e) Single Trip Daily and/or Top Up Premium: <i>line c) x line d)</i>	e) \$ _____	e) \$ _____
f) If you have smoked cigarettes during the 5 years prior to your effective date, add 20% of your premium (not applicable to the Canada Plan or the 55 to 74 Vacation Plan): <i>1.2 x line e)</i>	f) \$ _____	f) \$ _____
g) Single Trip Daily and/or Top Up Subtotal: <i>line e) + line f)</i>	\$ _____	\$ _____

3. Subtotal of lines 1 to 2: <i>line 1 d) + line 2 g)</i>	\$ _____	\$ _____
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4. Deductible options (add or subtract the appropriate % located on your rate sheet): <i>line 3 ± surcharge/discount%</i>	\$ _____	\$ _____
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5. Travel Companion Discount: If applicable, subtract 5% of line 4 for the respective applicant (refer to rate sheet for details): <i>0.95 x line 4</i>	\$ _____	\$ _____
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6. Top Up Surcharge: Indicate \$25 if you are topping up another carrier's coverage	\$ _____	\$ _____
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7. TOTAL TRAVEL INSURANCE PREMIUM: <i>line 5 + line 6</i>	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>
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TOTAL PAYMENT SUBMITTED FOR APPLICANT 1 AND APPLICANT 2 (The minimum premium is \$25 per person, per plan).....	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>
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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)