

--

APPLICANT 1

Applicant Information

APPLICANT 2

Last Name			Last Name		
First Name			First Name		
Date of birth (dd/mm/yy)	Age	Gender	Date of birth (dd/mm/yy)	Age	Gender
Government Health Plan # & version code			Government Health Plan # & version code		

Address in Canada

Civ. #	Street	Civ. #	Street
City		City	
Province	Postal Code	Province	Postal Code
Phone (1)	Phone (2)	Phone (1)	Phone (2)
Email		Email	

Travel Destination

City	State	Country	Phone
------	-------	---------	-------

Other travel coverage information (please specify if covered by other plan)

--

SECTION 1 – ARE YOU ELIGIBLE TO APPLY FOR COVERAGE?

You must meet the following eligibility requirements on the departure date of each trip to be eligible for coverage under this policy:

1. You must not have:
 - a) Amyotrophic Lateral Sclerosis (ALS/Lou Gehrig's Disease)
 - b) Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)
 - c) Cystic Fibrosis
 - d) received any treatment for pancreatic cancer, liver cancer or any type of cancer that has metastasized
 - e) home oxygen prescribed within the last 24 months
 - f) had a major organ transplant (heart, kidney, liver, lung)
 - g) had kidney dialysis within the last 12 months
 - h) had your most recent coronary by-pass surgery more than 12 years prior to the effective date (Use the date of your most recent bypass)
 - i) had more than one episode of pneumonia in the last 12 months
 - j) had an aneurysm that has not been surgically repaired
 - k) congestive heart failure?

SECTION 2 – In the past 6 months not have:

- a) taken or been prescribed a total of **6 or more** prescription medications (excluding aspirin) for one or more of the following: Cardiovascular condition, Cerebrovascular condition, Diabetes, Respiratory condition, High Blood Pressure.
- b) Cancer (not including basal or squamous cell carcinoma of the skin, or breast cancer treated only with Tamoxifen, Femara, Arimidex)
- c) received any new prescription medication or new medical treatment OR changes in your medication for:
 - i. a Cardiovascular or Cerebrovascular condition.
 - ii. a Combination of Diabetes treated with insulin and Cardiovascular/Cerebrovascular condition.

IMPORTANT NOTE: If 2a) – 2c) applies to you, coverage may be available if you complete a detailed medical questionnaire and receive a written offer of coverage from the insurer.

Cardiovascular means myocardial infarction, arrhythmia, atrial fibrillation, heart murmur, chest pain or angina, arteriosclerosis, congestive heart failure, by-pass or any other kind of cardiac surgery, angioplasty or stent, use of pacemaker or defibrillator or any other condition relating to the heart or cardiovascular system and peripheral vascular disease.

Cerebrovascular means Cerebrovascular accident (CVA), stroke, transient ischemic attack (TIA), aneurysm, or mini-stroke.

Respiratory means chronic obstructive pulmonary disease (COPD), bronchial asthma, chronic bronchitis, emphysema, or any other respiratory condition requiring the use of corticosteroids.

Section 3: Medical History (Only to be completed by applicants 56 and older)

If your answer is "yes" to any of these questions, you must check that box.	Applicant 1	Applicant 2
1. My last complete medical examination by a physician was more than 18 months ago.	<input type="checkbox"/> 15	<input type="checkbox"/> 15
2. Cardiovascular condition:		
a. In the last 12 months have you been treated, prescribed or taken any medication (other than aspirin) for, or as the result of: <ul style="list-style-type: none"> • coronary, vascular or carotid artery surgery, • blood clot(s) • heart attack (myocardial infarction) • coronary artery disease (including angina) • pericarditis • irregular (rapid or slow) heart beat or rhythm • heart murmur • arteriosclerosis 	<input type="checkbox"/> 85	<input type="checkbox"/> 85
b. In the last 12 months have you been treated, prescribed or taken any medication (other than aspirin) for, or as the result of peripheral vascular disease?		
c. I had an angioplasty or a bypass prior to my departure date?		
3. Cerebrovascular condition:		
a. In the last 12 months have you been treated, prescribed or taken any medication (excluding aspirin) for, or as the result of: cerebrovascular accident (CVA), stroke, transient ischemic attack (TIA) or mini-stroke?	<input type="checkbox"/> 70	<input type="checkbox"/> 70
4. Chronic Respiratory condition:		
a. In the last 12 months, have you been hospitalized, treated, prescribed or taken medication for chronic asthma or chronic bronchitis?	<input type="checkbox"/> 60	<input type="checkbox"/> 60
b. In the past 5 years, have you used home oxygen, prednisone for a respiratory condition or been diagnosed with emphysema or chronic obstructive pulmonary disease?	<input type="checkbox"/> 85	<input type="checkbox"/> 85
5. In the last 24 months, have you been treated, prescribed or taken medication for one of the following Gastrointestinal conditions:		
a. bowel obstruction or bowel surgery?	<input type="checkbox"/> 45	<input type="checkbox"/> 45
b. gastrointestinal bleeds, peptic ulcer, diverticulitis or ulcerative colitis?	<input type="checkbox"/> 35	<input type="checkbox"/> 35
6. In the last 12 months, have you been treated, prescribed or taken medication for one of the following conditions:		
a. kidney disorder including stones, spleen or pancreatic disorder?	<input type="checkbox"/> 15	<input type="checkbox"/> 15
b. liver disease?	<input type="checkbox"/> 45	<input type="checkbox"/> 45
c. Crohn's disease?	<input type="checkbox"/> 50	<input type="checkbox"/> 50
d. blood disorder (including hemophilia, sickle cell anemia, hemochromatosis)?	<input type="checkbox"/> 35	<input type="checkbox"/> 35
7. Cancer:		
a. In the last 2 years, have you had cancer requiring surgery, chemotherapy, radiation, or laser therapy (excluding removal of skin lesions)?	<input type="checkbox"/> 45	<input type="checkbox"/> 45
8. In the last 12 months, have you been treated, prescribed or taken medication for one of the following conditions:		
a. Parkinson's disease or seizures?	<input type="checkbox"/> 45	<input type="checkbox"/> 45
b. Diabetes – controlled by oral medication?	<input type="checkbox"/> 25	<input type="checkbox"/> 25
c. Diabetes – Insulin?	<input type="checkbox"/> 60	<input type="checkbox"/> 60
d. Alzheimer's disease/dementia?	<input type="checkbox"/> 35	<input type="checkbox"/> 35
e. High blood pressure (hypertension) (2 or more medications)?	<input type="checkbox"/> 25	<input type="checkbox"/> 25
f. Syncope, Dizziness, vertigo or fainting	<input type="checkbox"/> 35	<input type="checkbox"/> 35
9. In the last 12 months, have you been treated, prescribed or taken medication for a combination of High blood pressure (hypertension) and Diabetes (controlled by medication or insulin) ?	<input type="checkbox"/> 35	<input type="checkbox"/> 35
Points for Basic Coverage (Not Optional)	+ 100	+ 100
	Applicant 1	Applicant 2
TOTAL SCORE		2

Section 3: PREMIUM CALCULATION:

	Name of Applicant 1 (print)	Name of Applicant 2 (print)
Date of Departure (Day you leave your province or territory of residence)	dd mm yyyy	dd mm yyyy
Date Coverage Begins (Policy Effective Date)	dd mm yyyy	dd mm yyyy
Date Coverage Ends (Policy Expiry Date)	dd mm yyyy	dd mm yyyy
Total Number of Days Required (Count both the Date Coverage Begins and the Date Coverage Ends)		
Calculate Your Premium: Score	(1)	(1)
Your Rate From the Base Premium Rate Table	(2) \$	(2) \$
ANNUAL MULTI-TRIP PLAN selected?	8 Day <input type="checkbox"/> 16 Day <input type="checkbox"/> 24 Day <input type="checkbox"/> 32 Day <input type="checkbox"/> 48 Day <input type="checkbox"/>	8 Day <input type="checkbox"/> 16 Day <input type="checkbox"/> 24 Day <input type="checkbox"/> 32 Day <input type="checkbox"/> 48 Day <input type="checkbox"/>
ANNUAL MULTI-TRIP premium if selected	(3) \$	(3) \$
SUBTOTAL: (2) + (3)	(4) \$	(4) \$
Rate Factor: (1) ÷ 100	(5)	(5)
SUBTOTAL (4) x (5)	(6) \$	(6) \$
I have used tobacco products in the last 12 months	(7) ↑ +10%	↑ +10%
SUBTOTAL (6) X 10%	(8)	
CDN Deductible	\$ 250 (-5%) <input type="checkbox"/> \$ 1,000 (-10%) <input type="checkbox"/> \$ 5,000 (-25%) <input type="checkbox"/> \$ 10,000 (-30%) <input type="checkbox"/> \$ 100,000 (-50%) <input type="checkbox"/>	\$ 250 (-5%) <input type="checkbox"/> \$ 1,000 (-10%) <input type="checkbox"/> \$ 5,000 (-25%) <input type="checkbox"/> \$ 10,000 (-30%) <input type="checkbox"/> \$ 100,000 (-50%) <input type="checkbox"/>
SUBTOTAL		
Travelling Companion Discount:	↑ - 5%	↑ - 5%
TOTAL		
<input type="checkbox"/> Family coverage*		
Applicant 1 Premium Due + Applicant 2 Premium Due:		

*Family coverage applies only if all applicants are under 55 and is calculated by multiplying the older applicant's premium by 2.

APPLICANT 1

COVERAGE REQUESTED:
 1. Annual
 8 days 16 days 24 days 32 days 48 days \$ _____
 2. Daily Plan number of insured days _____ = \$ _____
 3. Deductible
 \$250 \$ 1 000 \$ 5 000 \$10 000 \$100 000
TOTAL \$ _____

PAYMENT
 CHEQUE
 VISA MasterCard AMEX
 Expiration date ____/____/____ Authorization # _____
 The vendor's name on the credit card statement will be **SECURIGLOBE INC**

APPLICANT 2

COVERAGE REQUESTED:
 1. Annual
 8 days 16 days 24 days 32 days 48 days \$ _____
 2. Daily Plan number of insured days _____ = \$ _____
 3. Deductible
 \$250 \$ 1 000 \$ 5 000 \$10 000 \$100 000
TOTAL \$ _____

PAYMENT
 CHEQUE
 VISA MasterCard AMEX
 Expiration date ____/____/____ Authorization # _____
 The vendor's name on the credit card statement will be **SECURIGLOBE INC**

I hereby declare that the information provided is truthful, complete and accurate. I understand that this application constitutes part of the contract provided by Co-operators Life Insurance Company. I acknowledge that any misrepresentations and non-disclosure of my medical status will result in non-payment of my claim and render my coverage null and void resulting in the refund of my premium.

If my health status or medication changes between the date this application is completed and any Effective Date, I must immediately notify Co-operators Life Insurance Company of those changes otherwise my coverage will be null and void.

I authorize any organization or person having any records or knowledge of my health to give any and all information regarding my health, medical history and treatment to WSA Assistance Inc, Co-operators Life Insurance Company or its authorized representatives. I understand that Co-operators Life Insurance Company will collect, use, and or/ disclose my personal information to provide me with the requested insurance services, for any other use authorized by me, and/or as required by law.

I acknowledge that this coverage is subject to exclusions, terms, conditions and limitations that may limit or exclude an amount payable. A reproduction of this Authorization & Declaration shall be as valid as the original. I understand and agree that refusal or withdrawal of this authorization will result in denial of my application.

I acknowledge I have reviewed and confirm my agreement with the Notice of Privacy and Confidentiality as indicated below. This acknowledged that information may be transmitted by facsimile (fax), e-mail, postal service, courier service or telephone, and we cannot guarantee the security or privacy of the information that is transmitted through these channels.

Notice of Privacy and Confidentiality: The information requested in the Insurance Application is required to process the application for Insurance, and in the event of a claim, is required to adjudicate your claim. To protect its confidentiality, access to this information will be restricted to those employees, mandataries, administrators or agents of Co-operators Life Insurance Company and member companies of The Co-operators who are responsible for administration of services, underwriting, and marketing; and for the processing, facilitating and investigation of claims. When necessary, this information may be shared with others such as, but not limited to, medical facilities, insurance companies, organizations, and to any other person you authorize or that is authorized by law. Contact us for a copy of our Privacy Policy.

 Applicant 1 Name (print)

Signature of Applicant

MM/DD/YYYY

 Applicant 2 Name (print)

Signature of Applicant

MM/DD/YYYY

 Broker Name (print)

Signature of Broker

MM/DD/YYYY