



# Application for Emergency Travel Medical Insurance

Effective October 2009

Application for PrimeLink or PrimeLink Plus single trip plans, annual multiple trip plans, and top-up plans.

## Personal Information

### ● APPLICANT 1

First Name		Last Name	
Date of Birth	dd / mm / yy	Male	Female
E-mail address			

### ● APPLICANT 2

First Name		Last Name	
Date of Birth	dd / mm / yy	Male	Female
E-mail address			

### Home Address

Street No.	Street Name	Unit Number	City	Province	Postal Code	( )
------------	-------------	-------------	------	----------	-------------	-----

### Destination Address

Street No.	Street Name	Unit Number	City	Province / State	Postal Code / Zip Code	( )
------------	-------------	-------------	------	------------------	------------------------	-----

### Emergency Contact (optional)

Name	( )
------	-----

Family Members	First Name	Last Name	Male / Female	Date of Birth
Dependent 1			Male <input type="checkbox"/> Female <input type="checkbox"/>	dd / mm / yy
Dependent 2			Male <input type="checkbox"/> Female <input type="checkbox"/>	dd / mm / yy
Dependent 3			Male <input type="checkbox"/> Female <input type="checkbox"/>	dd / mm / yy

Include additional dependents on sheet of paper and attached to this application

## Travel Information

### Application for Single Trips and Top-Ups

Insured's under single trip plans must be travelling together

Departure Date	dd / mm / yy	Total Trip Days
Effective Date	dd / mm / yy	
Return Date	dd / mm / yy	
<input type="checkbox"/> Applying for a family plan (include the dependents noted above)		

### Application for Annual Multi trip Plans

Effective Date	dd / mm / yy
Duration:	<input type="checkbox"/> 9 Day <input type="checkbox"/> 16 Day <input type="checkbox"/> 32 Day <input type="checkbox"/> 60 Day (under age 60)
<input type="checkbox"/> Applying for a family plan (include the dependents noted above)	

# Definitions

"**Change in Medication**" means the medication dosage or frequency has been reduced, increased, stopped and/or new medication(s) have been prescribed.

*Change in medication* exceptions: The following does not constitute a *change in medication*:

- The routine adjustment of insulin, coumadin or warfarin (as long as they are not newly prescribed or stopped);
- A change from a brand name medication to a generic brand medication (same dosage);
- Cholesterol reducing medication, hormone replacement medication, vitamins, minerals and non-prescription medication;
- Adjustment of Aspirin (or Entrophen) if taken for a heart condition provided it is not being taken in conjunction with other heart medication.

"**Change in Treatment**" means that:


- You have been admitted to a hospital;
- A physician has recommended or prescribed a *change in medication*;
- You have undergone or are awaiting medical investigation or a surgical procedure, or sought a diagnosis; and/or
- You have taken nitro-glycerine more than once per week, specifically for the relief of angina pain.

"**Minor Ailment**" means a sickness or injury which does not require the use of medication for a period greater than 14 days, more than one follow-up visit to a physician, hospitalization, or surgical intervention and which ends at least 30 days prior to your departure date. However, a condition or complications thereof which require continuous and ongoing medical attention or *treatment* is not considered a *minor ailment*.

"**Pre-existing Condition**" means any medical condition or symptom, that existed before your effective date. A *minor ailment* is not considered a *pre-existing condition*.


"**Stable**" means that the medical condition has not worsened; symptoms have not become more frequent or more severe; there has been no test result(s) showing deterioration, no new symptoms, no new or *change in treatment* and/or no medical attention prescribed or recommended by a physician; and there has been no hospitalization and you are not awaiting any test results.

"**Treatment**" means any medical, therapeutic or diagnostic procedure prescribed or performed or recommended by a licensed medical practitioner, including but not limited to prescription medication, investigative testing, and surgery related to any sickness, injury or symptom.

 If you are under age 55, proceed to the Premium & Payment section on page 4.  
If you have Alzheimer's or dementia, please consult your physician when completing your application.

## Eligibility • required for applicants age 55 and over

Applicant 1	Applicant 2	Answer each question by checking YES or NO for each applicant
1. <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have a terminal illness or metastatic cancer or are you travelling against the advice of your physician?
2. <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have AIDS or an AIDS related complex or HIV (Human Immunodeficiency Virus)?
3. <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you ever had an organ or bone marrow transplant (except cornea or skin graft)?
4. <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you ever had kidney dialysis?

 If you have answered "**YES**" to **ANY** of these questions you do not qualify for PrimeLink.  
If you have answered "**NO**" to **ALL** of these questions, please proceed to Plan Eligibility section.

## Plan Eligibility • required for applicants age 55 and over

5. <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have an aneurysm greater than 4cm in diameter, width or length?
6. a) <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<b>In the past 6 months</b> , have you: had a stroke or mini-stroke (TIA or Transient Ischemic Attack)? received treatment for narrowing or blockage of any artery or peripheral vascular disease? been treated in a hospital for any heart condition?
b) <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
c) <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
7. <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<b>In the past 12 months</b> , have you received <i>treatment</i> for a lung condition requiring the use of oxygen or Prednisone?
8. <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<b>In the past 12 months</b> , have you received <i>treatment</i> for 3 or more of the following conditions? <ul style="list-style-type: none"> <li>● heart condition</li> <li>● liver disorder</li> <li>● high blood pressure</li> <li>● diabetes (requiring medication or insulin)</li> <li>● stroke or mini-stroke (TIA or Transient Ischemic Attack)</li> <li>● lung condition (excluding <i>minor ailments</i>)</li> </ul>
9. <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<b>In the past 4 months</b> , have you been prescribed or taken 5 or more medications for any of the following conditions? <ul style="list-style-type: none"> <li>● heart condition</li> <li>● liver disorder</li> <li>● high blood pressure</li> <li>● diabetes (requiring medication or insulin)</li> <li>● stroke or mini-stroke (TIA or Transient Ischemic Attack)</li> <li>● lung condition (medication includes puffer(s)/inhaler(s))</li> </ul>
10. a) <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<b>In the past 18 months</b> , have you: received <i>treatment</i> for heart failure? been prescribed or taken any medication for heart failure? Medication may include but is not limited to: bumetanide, Bumex, ethacrynic acid, Edecrin, furosemide, Lasix, toseamide or Demadex.
b) <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
11. <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you had heart bypass surgery <b>more than 10 years ago</b> (Answer "NO" to this question if you have had additional bypass surgery in the past 10 years)?

 If you have answered "**YES**" to **ANY** of these questions you do not qualify for PrimeLink; however, other coverage options are available. Contact us to determine alternative options.  
If you have answered "**NO**" to **ALL** of these questions, please proceed to Plan/Rate Qualification section.

# Plan/Rate Qualification

• required for applicants age 55 and over

## SECTION A

Applicant 1   Applicant 2   Answer each question by checking the YES or NO box for each applicant

1.    YES    NO    YES    NO   **In the past 24 months**, have you smoked any tobacco products?

## SECTION B

2.    YES    NO    YES    NO   Has it been **longer than 24 months** since your last regular check-up with a physician?

3.    YES    NO    YES    NO   Have you **ever** received *treatment* for a heart condition?

4.   **In the past 36 months**, have you received *treatment* for:

- a)    YES    NO    YES    NO   Lung condition (excluding *minor ailments*)
- b)    YES    NO    YES    NO   Diabetes (requiring medication or insulin)
- c)    YES    NO    YES    NO   Stroke or mini-stroke (TIA or Transient Ischemic Attack)
- d)    YES    NO    YES    NO   Liver disorder
- e)    YES    NO    YES    NO   Kidney disorder (including stones)
- f)    YES    NO    YES    NO   Cancer (except basal and squamous cell skin cancer)
- g)    YES    NO    YES    NO   Aneurysm

5.   **In the past 24 months**, have you received *treatment* for:

- a)    YES    NO    YES    NO   Gastro-intestinal bleeding
- b)    YES    NO    YES    NO   Alzheimer's disease/dementia
- c)    YES    NO    YES    NO   Pancreatic disorder
- d)    YES    NO    YES    NO   Bowel obstruction or surgery



If you have answered "NO" to **ALL** of the questions in Section B you qualify for Prime 1 rates and the 60 day stability period for *pre-existing condition* coverage applies to you. Proceed to the Premium and Payment Section.

If you have answered "YES" to **ANY** of the questions in Section B, proceed to Section C.

## SECTION C

6.   **In the past 12 months**, have you undergone a *change in treatment* for any of the following medical conditions?

- a)    YES    NO    YES    NO   Heart condition
- b)    YES    NO    YES    NO   Lung condition (excluding *minor ailments*)
- c)    YES    NO    YES    NO   Liver disorder
- d)    YES    NO    YES    NO   Kidney disorder (including stones)
- e)    YES    NO    YES    NO   Diabetes (requiring medication or insulin)
- f)    YES    NO    YES    NO   Stroke or mini-stroke (TIA or Transient Ischemic Attack)
- g)    YES    NO    YES    NO   Cancer (except basal and squamous cell skin cancer)
- h)    YES    NO    YES    NO   Aneurysm
- i)    YES    NO    YES    NO   Gastro-intestinal bleeding
- j)    YES    NO    YES    NO   Alzheimer's disease/dementia
- k)    YES    NO    YES    NO   Pancreatic disorder
- l)    YES    NO    YES    NO   Bowel obstruction or surgery

7.    YES    NO    YES    NO   **In the past 4 months**, have you been prescribed or used a puffer(s) or inhaler(s) other than for a minor ailment?



If you have answered "NO" to **ALL** of the questions in Section C you qualify for Prime 2 rates and the 90 day stability period for *pre-existing condition* coverage applies to you. Proceed to the Premium and Payment Section.

If you have answered "YES" to **ANY** of the questions in Section C you qualify for Prime 3 rates and the 180 day stability period for *pre-existing condition* coverage applies to you. Proceed to the Premium and Payment Section.

Based on the rate category for which you qualify, use the chart below to determine the period during which any *pre-existing condition* must be *stable* to be covered.

Rate Category	<i>Pre-existing condition</i> period
Under age 55	Your <i>pre-existing condition</i> must be <i>stable</i> for 60 days prior to departure
Prime 1	Your <i>pre-existing condition</i> must be <i>stable</i> for 60 days prior to departure
Prime 2	Your <i>pre-existing condition</i> must be <i>stable</i> for 90 days prior to departure
Prime 3	Your <i>pre-existing condition</i> must be <i>stable</i> for 180 days prior to departure

# Premium & Payment

To calculate your premium, you need to know the premium which applies to your Plan/Rate Qualification and trip duration as well as the deductible option you have chosen. The total amounts used to calculate your premium are to be indicated below. Please call the contact number in the box below for assistance in calculating your premium.

Premium Calculation Factors		Applicant 1				Applicant 2			
Product	Indicate the product you are applying for. PrimeLink Plus offers all of the benefits of PrimeLink in addition to: StandbyMD, a total coverage limit of \$5,000,000 and, for PrimeLink Plus Multi Trip Annual plans, unlimited coverage for travel within Canada.	<input type="checkbox"/> PrimeLink		<input type="checkbox"/> PrimeLink		<input type="checkbox"/> PrimeLink Plus		<input type="checkbox"/> PrimeLink Plus	
Plan/Rate	Check the box applicable to the Plan/Rate for which you qualify.	Under 55	PRIME 1	PRIME 2	PRIME 3	Under 55	PRIME 1	PRIME 2	PRIME 3
Deductible	Indicate the deductible amount selection. \$0 Default deductible; except the Prime 3 default is \$200.	\$				\$			
All Inclusive Coverage	Indicate if you are applying for All Inclusive coverage.	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
Top Up Fee	If topping up a plan other than a PrimeLink product, a \$20 fee will apply.	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
Smoker Surcharge	If you are age 55 or over and have smoked tobacco products in the past 24 months, a 15% surcharge applies.	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
Total Premium	The total premium amount for this insurance.	\$				\$			

Payment Method      Cheque

Name on Credit Card

—  —  —  mm / yy

Credit Card Number

Expiration Date

Cardholder Signature

The vendor's name on the credit card statement will be CanAm Special Risk Ins.

# Signatures

I declare that all the information I have provided on this application form is true and complete and I understand that any inaccurate or missing information on this application will void my policy. I understand that the italicized words have specific meanings and understand the terms and conditions that apply to my coverage.

I understand that expenses resulting from a *pre-existing condition* are not covered unless the *pre-existing condition* was *stable* prior to the effective date of my policy as per the following: under age 55 and Prime 1 – 60 days; Prime 2 – 90 days; Prime 3 – 180 days. I agree that if I have any change in my medical condition or *treatment* prior to the policy effective date, I will contact CanAm Insurance immediately.

I hereby authorize CanAm Insurance and the broker/brokerage named on this application (if applicable) to the use of the personal information provided herein for purposes of providing me with insurance services and that my personal information may be disclosed to any person or organization, including healthcare practitioners and institutions, investigative agency or other insurers or re-insurers in order to assess risk, administer this insurance, to investigate claims and to pay insurance benefits.

I am a Canadian resident and am insured under a Canadian Provincial or Territorial government health insurance plan.

I am not travelling against the advice of a physician or after the diagnosis of a terminal illness.

dd / mm / yy

Applicant 1 Signature

Date

dd / mm / yy

Applicant 2 Signature

Date

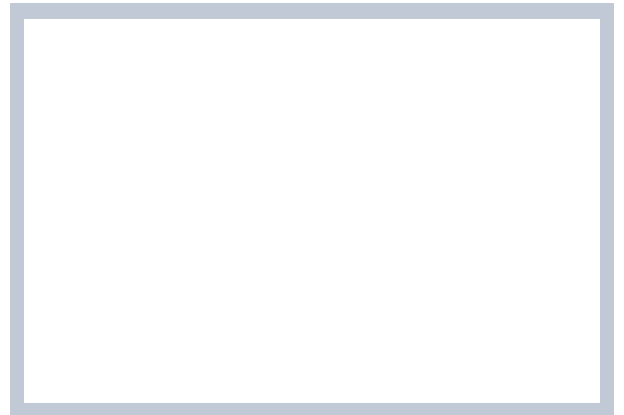
As the broker, you confirm by signing below that you have disclosed the following information to the applicant: the name of the company or companies you represent; that you receive commissions for the sale this insurance product and may receive bonuses, invitation to conferences or other incentives; and any conflicts of interest you may have with respect to this transaction.

dd / mm / yy

Broker Name (printed)

Signature

Date



The information in this application and existing files are used to offer products and services. Consent to the use of such information to offer products and services are optional and such use can be discontinued by writing or telephoning CanAm Insurance. A photocopy or facsimile of this authorization is as valid as the original.

PrimeLink is underwritten by The Manufacturers Life Insurance Company, and is administered by CanAm Insurance and medical assistance and claims services are provided by Active Care Management.