



TRAVEL INSURANCE APPLICATION FOR CANADIAN TRAVELLERS

If medical underwriting is required please use the appropriate form.
Language preference English French

STEP 1 APPLICANT INFORMATION (Please Print)

Sex	First Name	Last Name	Birth Date (mm/dd/yyyy)
M / F			
M / F			
M / F			
M / F			
M / F			
Address in Canada			
City/Prov.		Postal Code	
Telephone Number ()		E-mail Address	
Beneficiary Name		Relationship	

STEP 2 APPLICATION DETAILS (Please Print)

Application Date (mm/dd/yyyy)	Effective Date (mm/dd/yyyy)	For purchase of additional coverage. Previous Policy Number:
Time of Application _____ am _____ pm	Expiry Date (mm/dd/yyyy)	
Destination _____	No. of days coverage _____	
Departure Date (mm/dd/yyyy)	Departure Point _____	

STEP 3 COVERAGE SELECTION

Plans Purchased (check all that apply)	Premium Rate	# of Persons	# of Days	Total Premium
Emergency Hospital Medical Plans <input type="checkbox"/> U.S.A. Plan <input type="checkbox"/> Non-U.S.A. Plan <input type="checkbox"/> Group Sports Plan	\$			\$
Multi-trip Plans Trip Days: <input type="radio"/> 8 <input type="radio"/> 15 <input type="radio"/> 35 <input type="radio"/> 60 <input type="radio"/> 105 <input type="checkbox"/> Basic Plan <input type="checkbox"/> Select Plan: <input type="radio"/> Option 1 <input type="radio"/> Option 2	\$			\$
Trip Cancellation and Interruption Plans <input type="checkbox"/> Basic Plan <input type="checkbox"/> Select Plan After Departure Sum Insured – \$25,000 Enter Prior Departure Sum Insured \$ _____	\$			\$
All-inclusive Package Plans <input type="checkbox"/> U.S.A. Package Plan <input type="checkbox"/> Non-U.S.A. Package Plan <input type="checkbox"/> Youth Adventure Package After Departure Sum Insured – \$25,000 Enter Prior Departure Sum Insured \$ _____	\$			\$
Optional Plans <input type="checkbox"/> Baggage <input type="radio"/> \$1,000 <input type="radio"/> \$1,500 <input type="checkbox"/> A.D.&D. <input type="radio"/> \$25,000 <input type="radio"/> \$100,000 <input type="radio"/> \$250,000 <input type="checkbox"/> Flight Accident <input type="radio"/> \$200,000 <input type="radio"/> \$500,000 <input type="checkbox"/> Trip Interruption <input type="radio"/> \$800 <input type="radio"/> \$1,500 <input type="radio"/> \$2,000 <input type="checkbox"/> Rental Car Collision Damage: \$50,000	\$			\$
Minimum premium levels apply.	TOTAL PREMIUM DUE			\$

STEP 4 PAYMENT AND DECLARATION

<input type="checkbox"/> Visa <input type="checkbox"/> MC <input type="checkbox"/> Amex <input type="checkbox"/> Diners <input type="checkbox"/> Cheque Card No. _____ Expiry Date ____ / ____ Auth. No. _____ _____ Cardholder's Signature	Submit this Application to: Agency Code 2918 Kinnell Travel & Health Plans Inc. Fax: 705-721-5880 Phone: 705-737-4203 Mailing Address: Toll free: 1-800-238-8284 1410 – 64 Cedar Pointe Dr. Email: service@kinnellinsurance.com Barrie, ON L4N 5R7
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I am in good health and know of no reason to seek medical attention. I am aware that if I have any condition affecting my health, claims relating to this condition may be excluded under this policy.

Signature of insured (or person acting on behalf of Insured)

Date (MM/DD/YYYY)