

Kinnell Travel & Health Plans Inc.

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Application effective June 1st, 2008



3050, St-Jean Blvd., Trois-Rivieres (Quebec) G9B 2M9 • Phone: 1-800-268-9633 • Fax: 1-819-377-6069

This application and its medical declaration shall become an integral part of the policy which takes effect when the documents are duly completed and subject to the eligibility and insurability terms and conditions of the policy and received with the required premium by the Insurer before the departure date.

APPLICANT 1

D _____ M _____ Y _____
_____/_____/_____
_____/_____/_____
_____/_____/_____

< DEPARTURE DATE >
< EFFECTIVE DATE >
< EXPIRATION DATE >
< ANNUAL PLAN EFFECTIVE DATE >

APPLICANT 2

D _____ M _____ Y _____
_____/_____/_____
_____/_____/_____
_____/_____/_____

Are you covered by another insurance? Specify (ex. Group, retired, Medicare...): _____
Do you want additional insurance? A-1 Yes No A-2 Yes No

Language: F E

APPLICANT 1

Last Name _____
First Name _____
Date of Birth dd / mm / yyyy Age _____ Sex M F
During the last TWELVE (12) MONTHS, have you used any tobacco products?
Yes No
If you have answered YES, the smoker rate is applicable (see page 4, item #5).
Government Health Insurance N° _____
Attending Physician's Name _____
Date of your last doctor's visit dd / mm / yyyy
Doctor's Tel. N° (_____) _____
Reason _____

Language: F E

APPLICANT 2

Last Name _____
First Name _____
Date of Birth dd / mm / yyyy Age _____ Sex M F
During the last TWELVE (12) MONTHS, have you used any tobacco products?
Yes No
If you have answered YES, the smoker rate is applicable (see page 4, item #5).
Government Health Insurance N° _____
Attending Physician's Name _____
Date of your last doctor's visit dd / mm / yyyy
Doctor's Tel. N° (_____) _____
Reason _____

Address in Canada _____
Telephone N° in Canada (_____) _____ Emergency Telephone N° (_____) _____
Destination _____

DEPENDENTS

(required if insured under family plan)

(unmarried dependent children aged 3 months to 21 years)

Last Name _____	First Name _____	Date of birth <u>dd</u> / <u>mm</u> / <u>yyyy</u>	Age _____
Last Name _____	First Name _____	Date of birth <u>dd</u> / <u>mm</u> / <u>yyyy</u>	Age _____
Last Name _____	First Name _____	Date of birth <u>dd</u> / <u>mm</u> / <u>yyyy</u>	Age _____
Last Name _____	First Name _____	Date of birth <u>dd</u> / <u>mm</u> / <u>yyyy</u>	Age _____

ELIGIBILITY

You are **eligible** for coverage if you, on departure date, are aged 3 months or older for the TOUR+MED INTERNATIONAL Plan (single Trip), 3 months to 79 years for the ANNUAL Plan and maintain permanent residence in Québec, Ontario or New-Brunswick and are eligible for benefits under your respective Provincial Government Health Insurance plan.

You are **not eligible** for coverage under this policy if you suffer or have previously suffered from :

1. A condition for which a physician has recommended that you do not travel now or in the near future;
2. A terminal illness;
3. Kidney disease requiring dialysis and/or major organ transplants;
4. Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS);
5. Pancreatic cancer, liver cancer or any cancer with metastases;
6. A pulmonary condition that has required "home oxygen" within twelve (12) months prior to the application date.

I have read and understood the preceding eligibility criteria.

Initials: X _____ X _____
Applicant 1 Applicant 2

TRAVELERS OF ALL AGES: ANSWER ALL QUESTIONS

Travelers 85 years and older: You must submit an additional medical questionnaire for possible eligibility.

Your answers to the medical declaration constitute the basis of your eligibility. In any doubt, you should seek the help of your agent, our client representative or Your doctor. The Insurer reserves the right to request an additional medical questionnaire if needed.

- During the last twenty four (24) months, have you been diagnosed or received a medical treatment for a disease or symptoms related to three (3) or more of the following conditions : cardiac, vascular (including high blood pressure), diabetic, respiratory, neurological, gastro intestinal or cancer ?
- Have you ever been diagnosed or received treatment for heart failure (CHF), pulmonary oedema, cardiomyopathy or hepatitis C or D?
- Have you had bypass surgery, angioplasty, cardiac or vascular surgery (excluding the installation of a pacemaker) more than ten (10) years ago ? (refer to the least recent date)
- Have you ever been diagnosed with an arterial blockage or an aneurysm which still remains surgically untreated?

A-1		A-2	
Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the last twelve (12) months have you :

- Been investigated or consulted a doctor for chest pain, shortness of breath or for symptoms related to angina or a cardiac disease?
- Suffered from a respiratory disorder and used any tobacco products?
- Been hospitalized, had surgery or kept under an observation status at any hospital ER ? (Do not take into account minor accident for ER)
- Used or been prescribed a total of eight (8) medications and more ? (including prescribed as needed and aspirin, except hormones and vitamins)

A-1		A-2	
Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above questions 1 through 8, you are not eligible for coverage under this application.
For possible eligibility, you must submit an additional medical questionnaire and provide details for any affirmative answers.

STANDARD CLASS

Please answer the following question in regards to the 4 categories of diseases. In case of positive answer, please specify which specific disease(s) from the list. In case of uncertainty on the 4 categories, please refer to the underlying list.

9 a) In the **THREE (3) YEARS** preceding the date of this application, have you received a diagnosis, a medical treatment or taken prescribed medication (including prescribed as needed and aspirin) for one or more of the following conditions?

A-1		A-2	
Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CARDIAC OR VASCULAR DISORDERS			
<i>Specify</i>			
<input type="checkbox"/>	Aneurysm	<input type="checkbox"/>	
<input type="checkbox"/>	Angioplasty	<input type="checkbox"/>	
<input type="checkbox"/>	Bypass Surgery	<input type="checkbox"/>	
<input type="checkbox"/>	Cardiac Surgery	<input type="checkbox"/>	
<input type="checkbox"/>	Chest Pain /Angina	<input type="checkbox"/>	
<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	
<input type="checkbox"/>	Heart Failure (CHF)	<input type="checkbox"/>	
<input type="checkbox"/>	Irregular Heart Beat/ Pacemaker/Defibrilator	<input type="checkbox"/>	
<input type="checkbox"/>	Peripheral vascular disease	<input type="checkbox"/>	
<input type="checkbox"/>	Syncope (fainting spells)	<input type="checkbox"/>	
<input type="checkbox"/>	Thrombosis (with Coumadin)	<input type="checkbox"/>	
<input type="checkbox"/>	Valvular hearth disease	<input type="checkbox"/>	

A-1		A-2	
Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL DISORDERS			
<i>Specify</i>			
<input type="checkbox"/>	Alzheimer's disease	<input type="checkbox"/>	
<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	
<input type="checkbox"/>	Cerebro-Vascular Accident (CVA/Stroke)	<input type="checkbox"/>	
<input type="checkbox"/>	Dementia	<input type="checkbox"/>	
<input type="checkbox"/>	Dizziness/Vertigo	<input type="checkbox"/>	
<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	
<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	
<input type="checkbox"/>	Parkinson's disease	<input type="checkbox"/>	
<input type="checkbox"/>	Transient Ischemic Attack (TIA)	<input type="checkbox"/>	

A-1		A-2	
Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY DISORDERS			
<i>Specify</i>			
<input type="checkbox"/>	Asthma (except allergic)	<input type="checkbox"/>	
<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	
<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease (COPD)	<input type="checkbox"/>	
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	
<input type="checkbox"/>	Pneumonia (requiring hospitalization)	<input type="checkbox"/>	
<input type="checkbox"/>	Pulmonary Embolism	<input type="checkbox"/>	

A-1		A-2	
Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE OR KIDNEY DISORDERS			
<i>Specify</i>			
<input type="checkbox"/>	Cirrhosis	<input type="checkbox"/>	
<input type="checkbox"/>	Diabetes treated with insulin	<input type="checkbox"/>	
<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	
<input type="checkbox"/>	Kidney Failure	<input type="checkbox"/>	
<input type="checkbox"/>	Pancreatitis	<input type="checkbox"/>	

9 b) For the above-checked conditions, has there been, in the last **SIX (6) MONTHS**, a change in your health status, new treatments, changes in your treatments or in the frequency or in the dosage of your medication ? A-1 Yes No A-2 Yes No
If YES, you must submit an additional medical questionnaire and provide all details.

1 or 2 condition(s) = Standard Class

3 and more conditions = You must submit an additional medical questionnaire.

PREFERRED/OPTIMAL CLASS

10 a) In the last **TWELVE (12) MONTHS** preceding the date of this application, have you received a diagnosis, a medical treatment or taken prescribed medication (including prescribed as needed) for one or more of the following conditions?

A-1 Yes No		GASTRO INTESTINAL DISORDERS		A-2 Yes No			
<input type="checkbox"/>	<input type="checkbox"/>	<i>Specify</i>				<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	Biliary colic (gallbladder attack)	<input type="checkbox"/>			
<input type="checkbox"/>		<input type="checkbox"/>	Crohn's disease/Ulcerative Colitis	<input type="checkbox"/>			
<input type="checkbox"/>		<input type="checkbox"/>	Diverticulosis	<input type="checkbox"/>			
<input type="checkbox"/>		<input type="checkbox"/>	Gastro-Intestinal Bleeding	<input type="checkbox"/>			
<input type="checkbox"/>		<input type="checkbox"/>	Intestinal Occlusion	<input type="checkbox"/>			
<input type="checkbox"/>		<input type="checkbox"/>	Ulcer	<input type="checkbox"/>			

A-1 Yes No		BLOOD DISORDERS		A-2 Yes No			
<input type="checkbox"/>	<input type="checkbox"/>	<i>Specify</i>				<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	Anemia (Optimal Class)	<input type="checkbox"/>			
<input type="checkbox"/>		<input type="checkbox"/>	Thrombocytopenia (platelets) (Optimal Class)	<input type="checkbox"/>			

A-1 Yes No		CANCER (past 5 years)		A-2 Yes No			
<input type="checkbox"/>	<input type="checkbox"/>	<i>Specify</i>				<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	Cancer with 1 to year 5 years of stability and treatment free	<input type="checkbox"/>			
<input type="checkbox"/>		<input type="checkbox"/>	Cancer diagnosed in the last 12 months (with or without chemo/radio) (All cancers excluded)	<input type="checkbox"/>			
A1 Specify type: _____							
A2 Specify type: _____							
<i>Note: Do not take into account benign skin cancer (basal cell or squamous cell carcinoma) and Cancers of more than 5 years. Treatment free: do not take into account Tamoxifen or its equivalent.</i>							

Provide an answer for every conditions					
A-1 Yes No		OTHER SPECIFIC DISORDERS		A-2 Yes No	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergic asthma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis/Pneumonia (without hospitalization)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes with oral medication*	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure*	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thrombosis (without Coumadin)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder disorder	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate disorder	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary/Renal/Biliary Calculi (stones)	<input type="checkbox"/>	<input type="checkbox"/>

Up to 2 conditions = Preferred Class **3 or more conditions = Optimal Class**
 *Diabetes (oral medication) + High blood pressure = Standard Class

PREFERRED-PLUS CLASS

11. During the last **EIGHTEEN (18) MONTHS**, have you consulted a doctor for a general exam (check up) ?
 A-1 Yes No A-2 Yes No

If you have answered **NO** to all questions 1 to 10 and **YES** to the question 11, you qualify for the Preferred-Plus Class.
 If you have answered **NO** to all questions 1 to 10 and **NO** to the question 11, you qualify for the Preferred Class.
 Otherwise, the answer to this question does not modify your class.

Additional notes and comments _____

EXCLUSIONS PERTAINING TO THE PRE-EXISTING CONDITIONS

Benefits are not payable under this policy if losses sustained or expenses incurred are the direct or indirect result of any of any conditions or changes in your health (except a *Minor Ailment*) that have not been *Stable and Controlled* for a period of **three (3) months** before departure for insured aged **3 months to 60 years** and for a period of **six (6) months** before departure for insured aged **61 and over**, unless specified otherwise in writing by the Insurer. (Exception 61 and over: high blood pressure = 3 month stability if you do not have cardiac, vascular, respiratory or neurological conditions).

"Stable and controlled" means any medical condition (other than a *Minor ailment*) for which all the following statements are true:

- there has been no new diagnosis, *Treatment* or prescribed medication (including prescribed as needed);
- there has been no change in *Treatment* frequency or type, or change in medication, including the amount of medication to be taken, its dosage or the type of medication*;
 Exceptions: the routine adjustment of Coumadin, Warfarin, insulin or oral medication to control diabetes in order to maintain an optimal control (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);
- there have been no new symptoms, more frequent symptoms or more severe symptoms;
- there have been no test results showing deterioration;

5. 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.

"Treatment" - Any medical, therapeutic or diagnostic procedure prescribed, performed or recommended by a physician, including but not limited to prescribed medications (including prescribed as needed), investigative tests and surgery.

"Minor Ailment" - Any sickness or injury which does not require:

- the use of medication for a period of greater than 15 days, or
- more than one follow-up visit to a physician, or
- hospitalization or surgical intervention or referral to a specialist.

To be considered as a *Minor ailment*, the sickness or injury must end at least 30 consecutive days prior to the departure date of each trip. However, a chronic condition and a condition requiring on-going medical attention are not considered a *Minor Ailment*.

PREMIUM CALCULATION

APPLICANT 1

Traditional deductible with discounts (CAN\$)

- \$250 (10%) \$500 (15%) \$1,000 (20%) \$2,500 (25%)
 \$5,000 (30%) \$10,000 (40%) \$50,000 (55%) \$100,000 (70%)

- Preferred-Plus Preferred Optimal Standard

1. Number of insured days _____ = \$ _____
2. Annual Plan 18 days 33 days
 48 days 63 days = \$ _____
3. Deductible discount _____ % = \$ -
4. Top-Up fee (\$25, except if Annual / LS Mutual) = \$ _____

REFERENCE PREMIUM (1 + 2 + 3 + 4) = \$ _____

Rebates and Extra-premium

5. Smoker rate + 15 %
6. 2 Travelers discount - 5 %
(2 adults applying simultaneously and traveling together)
7. "Claim Free" discount (7-2007 to 6-2008) - 5 %
 Previous policy N° _____
8. Early Bird discount (if paid before September 30, 2008) - 5 %
- 8 a) Total % 5 to 9 _____ % = \$ _____
(Apply % total on reference premium)
9. Extra-Premium (if applicable) _____ x _____ = \$ _____
Number of days Premium

TOTAL PREMIUM (Reference Premium + 8 a) + 9) = \$ _____

APPLICANT 2

Traditional deductible with discounts (CAN\$)

- \$250 (10%) \$500 (15%) \$1,000 (20%) \$2,500 (25%)
 \$5,000 (30%) \$10,000 (40%) \$50,000 (55%) \$100,000 (70%)

- Preferred-Plus Preferred Optimal Standard

1. Number of insured days _____ = \$ _____
2. Annual Plan 18 days 33 days
 48 days 63 days = \$ _____
3. Deductible discount _____ % = \$ -
4. Top-Up fee (\$25, except if Annual / LS Mutual) = \$ _____

REFERENCE PREMIUM (1 + 2 + 3 + 4) = \$ _____

Rebates and Extra-premium



5. Smoker rate + 15 %
6. 2 Travelers discount - 5 %
(2 adults applying simultaneously and traveling together)
7. "Claim Free" discount (7-2007 to 6-2008) - 5 %
 Previous policy N° _____
8. Early Bird discount (if paid before September 30, 2008) - 5 %
- 8 a) Total % 5 to 9 _____ % = \$ _____
(Apply % total on reference premium)
9. Extra-Premium (if applicable) _____ x _____ = \$ _____

TOTAL PREMIUM (Reference Premium + 8 a) + 9) = \$ _____

Family Plan - 1.25 x total premium for both applicants / 1.5 x premium if only one applicant.
(Not available for stay longer than 48 days)

► **Total premium for 2 applicants** \$ _____
(including Family Plan if applicable)
(\$20 Minimum premium)

PAID BY : Applicant's cheque
 Agent's cheque

A-1 A-2
 
 
 Cash

Cheque received from : _____

Please make cheque payable to **LS Mutual**, at least **15 days** prior to the departure date.
The vendor's name on the credit card statement will be LS Mutual (La Survivance).

A-1

Expiration date: _____ Authorization N°: _____
mm yyyy

A-2

Expiration date: _____ Authorization N°: _____
mm yyyy

I hereby confirm that the statements and answers given herein are accurate, true and complete. I declare to have read and understood the above questions regarding my health status, as well as the restrictions on preexisting conditions (SECTION V of the policy). I understand that if I do not meet the eligibility requirements (SECTION II of the policy) and the policy requirements and if pertinent medical information is omitted and/or falsified, the Insurer may reduce my coverage and/or render my policy null and void.

I authorize the Insurer to obtain all medical information available from any health care organization concerning my medical history. I specifically authorize the Insurer and the Emergency Assistance to submit on my behalf to my Provincial Government Health Insurance Department, in accordance with applicable laws and regulations, my claims for insured medical and hospital services I received outside of my province of residence. A copy or facsimile of this authorization shall be deemed as valid as an original. I also authorize my agent in case of a claim, to transmit to the Insurer any telephone conversation recorded during the application process.

Benefits payable under this policy are subject to receipt of this application duly **signed by the Applicant**. I understand that the Insurer retains all recovery rights on amount paid in good faith if it is subsequently determined that the Insured was not eligible (policy section IX, #13). Once signed, this document must be returned as soon as possible to the Insurer.

I understand that any change in my health status, prior to my departure date or effective date, must be reported to the Insurer. Failure to do so, the Insurer reserves the right to decline eligibility and coverage.

APPLICANT 1

Date: _____

Signature: X _____

APPLICANT 2

Date: _____

Signature: X _____

AGENT'S DECLARATION: I confirm that I have asked all the questions as written on this application, have explained the eligibility criteria of this application and confirm that all the declarations and answers were those of the applicant(s).

By phone In person By a third party: _____
Name of the third party

Agent's Signature: _____ Agent's Code: **V331**