

## Travel Choice 2 Travel Insurance

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# Medical Questionnaire and Application for Travelling Canadians

## Instructions

Medical questions help us to determine your eligibility and premium rate.

1. If you are under the age of 60 and meet the Eligibility requirements in Section A Step 1, complete Section A Step 2 and Section B.
2. All other applicants must complete the entire Medical Questionnaire to apply for this insurance. If you are uncertain of your answers to any medical questions, please consult your doctor before completing this Medical Questionnaire.
3. All applications must be completed before the effective date of insurance.

## Plan Information

**Emergency Medical Single-Trip Plan** – Provides coverage for a single trip while travelling outside your province or territory of residence.

**Emergency Medical Multi-Trip Plan** – Provides coverage for any number of trips up to the option you selected (4, 10, 18, 30 or 60 days). Trips must be separated by a return to your province or territory of residence or Canada. The Multi-Trip Plans offer unlimited travel within Canada (excluding your province or territory of residence).

**Travel Canada Emergency Medical Plan** – Provides coverage for a single trip while travelling within Canada and outside your province or territory of residence.

## Definitions

Italicized words have a specific meaning. Please refer to the following definitions when completing the Medical Questionnaire.

**Change in medication** means the medication dosage, frequency or type has been reduced, increased, or stopped and/or new medication has been prescribed. Exceptions: the routine adjustment of Coumadin, warfarin or insulin (as long as they are not newly prescribed or stopped) and there has been no change in your *medical condition*; and a change from a brand name medication to a generic brand medication of the same dosage.

**Medical condition** means any disease, sickness or injury (including symptoms of undiagnosed conditions).

**Pre-existing medical condition** means any *medical condition* that exists before your effective date.

**Stable** – A *medical condition* is considered *stable* when all of the following statements are true:

1. there has not been any new *treatment* prescribed or recommended, or change(s) to existing *treatment* (including a stoppage in *treatment*), and
2. there has not been any *change in medication*, or any recommendation or starting of a new prescription drug, and
3. the *medical condition* has not become worse, and
4. there has not been any new, more frequent or more severe symptoms, and
5. there has been no hospitalization or referral to a specialist, and
6. there have not been any tests, investigation or *treatment* recommended, but not yet complete, nor any outstanding test results, and
7. there is no planned or pending *treatment*.

All of the above conditions must be met for a *medical condition* to be considered *stable*.

**Treatment, Treated** means hospitalization, a procedure prescribed, performed or recommended by a physician for a *medical condition*. This includes but is not limited to prescribed medication, investigative testing and surgery. IMPORTANT: Any reference to testing, tests, test results, or investigations excludes genetic tests. “Genetic test” means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.

# Section A • Medical Questionnaire

## NAME OF APPLICANTS

Applicant 1

Applicant 2

### Step 1 • Are you eligible for coverage?

**Eligibility.** You must be at least 30 days of age and a Canadian resident covered by the Government Health Insurance Plan in your province or territory of residence for the entire duration of your trip. Coverage is NOT AVAILABLE under this policy or the Individual Medical Underwritten plan to any person who:

- is travelling against the advice of a physician;
- is diagnosed with a terminal illness or metastatic cancer;
- requires kidney dialysis;
- has been prescribed or used home oxygen in the last twelve (12) months;
- has had a bone marrow, stem cell or organ transplant (excluding cornea).

If you are not eligible to purchase this insurance, DO NOT complete this application.

### Step 2 • Your Declaration – Please read carefully before signing

I am eligible to apply to The Manufacturers Life Insurance Company (Manulife) for insurance under the Travel Choice 2 Travel Insurance policy. I declare that all the information I am providing on this application is true and complete. I understand the meaning of *treatment/treated*, as defined and used in this questionnaire.

I understand this coverage is subject to terms, conditions, limitations and exclusions (including the *pre-existing medical condition* exclusion) and that this coverage may exclude or limit an amount payable if I have a claim. I understand that if I misrepresent any material information provided in this application, Manulife will void my policy and I will not be covered for any benefits under this policy.

I authorize any hospital, physician, other medical service provider or any other organization or person that has any records or knowledge of me or my health to release to the assistance and claims service provider and/or Manulife and its reinsurers any such information for the purpose of this application and contract and any subsequent claim.

\_\_\_\_\_  
Applicant 1 Signature

\_\_\_\_\_  
Applicant 2 Signature

\_\_\_\_\_  
Date Signed

### Step 3 • Do you require Individual Medical Underwriting?

You will need to answer the following questions to determine if you are eligible to purchase this insurance or our Individual Medical Underwriting Plan.

If you are unsure of your answer to any medical question, consult your doctor before completing this application.

	Applicant 1		Applicant 2	
	Yes	No	Yes	No
1. Have you had a heart bypass, coronary angioplasty or heart valve surgery <b>more than ten (10) years ago?</b>	Yes	No	Yes	No
2. In the last <b>three (3) years</b> , have you been diagnosed with, taken or been prescribed medication, or been <i>treated</i> for <b>any two (2)</b> of the following? (if you only have one (1) of the following conditions, answer NO)				
• Heart condition;				
• Lung condition (except unrepeated prescription medications used for a single episode) (medication includes any puffers/inhalers);				
• Stroke/CVA (cerebrovascular accident) or mini-stroke/TIA (transient ischemic attack) (medication includes use of aspirin/Entrophen for this condition);				
• Diabetes ( <i>treated</i> with medication and/or insulin);				
• Narrowed or blocked artery in the legs (also called Peripheral Vascular Disease).	Yes	No	Yes	No
3. In the last <b>two (2) years</b> , have you:				
a) been diagnosed with, taken or been prescribed medication, or been <i>treated</i> for heart failure or congestive heart failure; and/or				
b) been prescribed or taken Lasix or furosemide or a water pill for ankle or leg swelling or water on the lungs?	Yes	No	Yes	No
4. In the last <b>twelve (12) months</b> , have you had:				
a) a new heart condition, or had an existing heart condition for which you had a <i>change in medication</i> or were hospitalized (as an inpatient or seen in the emergency department); and/or	Yes	No	Yes	No
b) shortness of breath or chest pain for which you sought <i>treatment</i> ; and/or	Yes	No	Yes	No
c) a lung condition for which you were hospitalized (as an inpatient or seen in the emergency department) or for which you have been prescribed or taken prednisone; and/or	Yes	No	Yes	No
d) cancer or received chemotherapy and/or radiotherapy and/or other <i>treatment</i> , other than routine follow-up, for cancer (except basal cell and squamous cell skin cancer, and breast cancer <i>treated</i> only with hormonal therapy)?	Yes	No	Yes	No
5. In the last <b>four (4) months</b> , have you been prescribed or taken <b>six (6) or more</b> prescription medications? <b>Do not count</b> the following medications: hormone replacement therapy (thyroid or menopausal); drugs used for osteoporosis or traveller's diarrhea; or any form of immunization. Do not count topical medications that go in your nose, ears or eyes or on your scalp or skin <b>except</b> any form of nitroglycerine or any drug(s) for angina.	Yes	No	Yes	No

If you must answer "YES" to ANY of the above questions, **you are not eligible** to purchase this insurance. Please call 1-866-991-9104 toll free if you wish to obtain a quote for our Individual Medical Underwriting plan for coverage of your *pre-existing medical conditions*.

If you answered "NO" to ALL of the above questions, you are eligible to purchase this insurance. Proceed to Step 4.

## Step 4 • Find Your Rate Category

### Part 1 • Smoking Status

	Applicant 1		Applicant 2	
1. In the last two (2) years, have you smoked cigarettes and/or used vaping products or e-cigarettes?	Yes	No	Yes	No

### Part 2 • Rate Qualification

	Applicant 1		Applicant 2	
1. Have you <b>ever</b> been diagnosed with or <i>treated</i> for: a) a heart condition; and/or b) any of the following conditions: <ul style="list-style-type: none"><li>• Aortic aneurysm (including thoracic or abdominal aneurysm)</li><li>• Cirrhosis of the liver;</li><li>• Parkinson's disease;</li><li>• Alzheimer's disease or other form of dementia?</li></ul>	Yes	No	Yes	No
2. In the last <b>three (3) months</b> , have you been prescribed or taken a total of <b>three (3) or more</b> medications for high blood pressure (hypertension)?	Yes	No	Yes	No
3. In the last <b>five (5) years</b> , have you been diagnosed with, taken or been prescribed medication for, or been <i>treated</i> for any of the following: <ul style="list-style-type: none"><li>• Lung condition (except unrepeated prescription medications used for single episode) (medication includes any puffers/inhalers);</li><li>• Stroke/CVA (cerebrovascular accident) or mini-stroke/TIA (transient ischemic attack) (medication includes use of aspirin/Entrophen for this condition);</li><li>• Diabetes (if <i>treated</i> with medication and/or insulin);</li><li>• Narrowed or blocked artery in the legs or in the neck?</li></ul>	Yes	No	Yes	No

If you answered "YES" to ANY question in Step 4 • Part 2, you qualify for Rate Category C.

If you answered "NO" to ALL questions in Step 4 • Part 2, you must answer the questions in Step 4 • Part 3.

### Part 3 • Rate Qualification

	Applicant 1		Applicant 2	
1. In the last <b>two (2) years</b> , have you been diagnosed with, taken or been prescribed medication, or <i>treated</i> for any of the following conditions? <ul style="list-style-type: none"><li>• Gastrointestinal bleeding or bowel obstruction or have had bowel surgery;</li><li>• Chronic bowel disorder (such as but not limited to Crohn's disease or Ulcerative colitis);</li><li>• Kidney disorder (including stones) or liver disorder or pancreatitis;</li><li>• Gallbladder disorder (including stones. Not applicable if gallbladder has been removed.)</li></ul>	Yes	No	Yes	No
2. In the last <b>two (2) years</b> , have you been diagnosed with, and/or <i>treated</i> by a hematologist or an internist for a blood disorder?	Yes	No	Yes	No
3. Are you over 70, and have you had a fall for which you sought medical attention in the last <b>six (6) months</b> ?	Yes	No	Yes	No
4. In the last <b>six (6) months</b> , have you received advice or <i>treatment more than twice</i> in the emergency room of a hospital?	Yes	No	Yes	No

If you answered "YES" to ANY question in Step 4 • Part 3, you qualify for Rate Category B.

If you answered "NO" to ALL questions in Step 4 • Part 3, you qualify for Rate Category A.

## RATE CATEGORY

I am 60 years of age or older and based on my answers above, I qualify for the following rate category:

**Applicant 1:**     A             B             C             **Applicant 2:**     A             B             C

**IMPORTANT:** The rate category you qualify for determines the *pre-existing medical condition* exclusion that applies to your coverage.

The *pre-existing medical condition* exclusions are detailed below.

**NOTE:** If you prefer to have your *pre-existing medical conditions* covered, call 1-866-991-9104 toll free if you wish to obtain a quote for our Individual Medical Underwriting Plan. You may be provided with a quote for a **single-trip emergency medical plan and have your *pre-existing medical conditions* covered.**

## Rate Categories and Pre-existing Medical Condition Exclusion

The following *pre-existing medical condition* exclusion applies to your Rate Category. All applicants 59 years of age or younger automatically qualify for Rate Category A.

**Rate Category A.** We will not pay any expenses relating to:

- a *pre-existing medical condition* that is not *stable* in the **three (3) months** before your effective date; and/or
- your heart condition if, in the **three (3) months** before your effective date, any heart condition has not been *stable* or you have taken any form of nitroglycerine for the relief of angina pain; and/or
- your lung condition if, in the **three (3) months** before your effective date, any lung condition has not been *stable* or you required *treatment* with oxygen or prednisone for your lung condition.

**Rate Categories B and C.** We will not pay any expenses relating to:

- a *pre-existing medical condition* that is not *stable* in the **six (6) months** before your effective date; and/or
- your heart condition if, in the **six (6) months** before your effective date, any heart condition has not been *stable* or you have taken any form of nitroglycerine for the relief of angina pain; and/or
- your lung condition if, in the **six (6) months** before your effective date, any lung condition has not been *stable* or you required *treatment* with oxygen or prednisone for your lung condition.

# Section B • Insurance Application

## APPLICANTS Home Address

1. Last Name, First Name				Date of Birth	
Street	Apt No.	City	Province	Postal Code	
Home Phone #	Work Phone #	Email (optional)	Country of Destination	Phone # at Destination	

2. Last Name, First Name				Date of Birth	
Street	Apt No.	City	Province	Postal Code	
Home Phone #	Work Phone #	Email (optional)	Country of Destination	Phone # at Destination	

TRAVEL INFORMATION (select your Emergency Medical plan)	APPLICANT 1					APPLICANT 2								
1. Multi-Trip Plan – covers multiple trips for 365 days	4 days	10 days	18 days	30 days	60 days	Effective date	(MM/DD/YYYY)	4 days	10 days	18 days	30 days	60 days	Effective date	(MM/DD/YYYY)
2. Single-Trip or Top-Up Duration	Departure Date					Departure Date								
	Effective Date*					Effective Date*								
	Expiry Date					Expiry Date								
	Total # of Days**					Total # of Days**								

\* Coverage will begin on the effective date you choose. 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.  
 \*\* Count your effective date, your expiry date and the days in between.

### SAVINGS OPTION

Deductible Savings: All published rates include a zero deductible. Not applicable to Travel Canada Emergency Medical Plan.

Deductible (\$ CDN)	\$0	\$500	\$1,000	\$5,000	\$10,000				Savings Applied
Savings Amount	0%	10%	15%	30%	35%				%
Travel Canada Emergency Medical Plan*: Cannot be combined with a Deductible Savings.									50%

\* Entire trip must be in Canada.

### CALCULATE YOUR PREMIUM

	Applicant 1	Applicant 2
1. Rate Category		
2. Multi-Trip Premium – (premium for trip length you selected)	+ \$	+ \$
3. Single-Trip or Top-Up Premium (number of days * X daily rate applicable to the TOTAL NUMBER OF DAYS IN YOUR TRIP)	+ \$	+ \$
4. SUBTOTAL	= \$	= \$
5. Savings Option – (Line 4 X % selected in SAVINGS OPTION)	\$	\$
6. Travel Companion Savings – (Line 4 X 5% for each applicant, if applicable)	\$	\$
7. TOTAL SAVINGS – (ADD Lines 5 and 6)	\$	\$
8. SUBTOTAL (line 4 LESS line 7)	\$	\$
9. Smoker's Surcharge – if you are age 60 or over and have smoked cigarettes and/or used vaping products or e-cigarettes in the last two (2) years prior to the date of this application, calculate Line 4 X 10%	\$	\$
10. TOTAL PREMIUM per Applicant (ADD line 8 and line 9)	\$	\$
11. TOTAL PAYMENT (submitted for Applicant 1 PLUS Applicant 2)	\$	\$

\* Use "Total # of Days" as defined under TRAVEL INFORMATION

**Payment Method:**  Visa  MasterCard  Cheque (payable to CanAm Insurance)

Cardholder's Name

Cardholder's Signature

Credit Card Number

Expiry Date

**Note: Coverage will not take effect if your credit card number is invalid or payment is rejected for any reason.**

**Mail this application with your payment to CanAm Insurance PO Box 62, Station A, Windsor ON N9A 6J5.**

### Advisor's Report • For Advisor/Agent Use Only

You confirm 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 of life and accident, sickness insurance products and may receive bonuses, invitations to conferences or other incentives; and
- any conflicts of interest you may have with respect to this transaction.

Your name (first, middle initial, last)	Advisor code	Signature	
<b>Vertis Insurance Solutions Ltd.</b>	<b>1 (866) 943-5997</b>	<b>(519) 974-5885</b>	<b>578100</b>
Agent name	Telephone number	Fax number	Agent selling code
<b>Vertis Insurance Solutions Ltd. PO Box 62, Station A, Windsor ON N9A 6J5</b>	<b>vertisinsurance@canamins.com</b>	<b>Vertis</b>	
Company name and address	Email address	Resource centre code	

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