

Underwritten by: Co-operators Life Insurance Company
Assistance Services by: SelectCare Worldwide
Managed by: PlanDirect Insurance Services Inc.

Questions? Contact Destination: Travel Health Plans at 1-800-337-3532
 Please refer to #50000081 when calling us

APPLICATION FOR INSURANCE

Part 1 – Eligibility Requirements:

Medical Questionnaire:

First Name First Name

If you are unsure of your eligibility based on your medical history, please consult with your physician.

You must complete the following eligibility requirements if you are age 50 or over on your date of application.

Applicant 1 Applicant 2

Table One			
	high blood pressure (hypertension)	diabetes (excluding diet controlled diabetes)	stroke (CVA)
	heart attack (myocardial infarction)	kidney (or renal) failure	transient ischemic attack (TIA)
	coronary artery disease	a liver disorder	peripheral vascular disease
	angina	pancreatitis	blood clot(s)
	atrial fibrillation	chronic obstructive pulmonary disease (COPD)	diverticulitis/diverticulosis
	irregular heart beat or rhythm	asthma	Crohn's disease
	heart valvular disease	chronic bronchitis	ulcerative colitis
	any other heart condition	any other lung disorder	any other bowel disorder

1. Have you been hospitalized for 24 hours or more during the 12 months prior to your departure date for anything listed in Table One above: YES NO YES NO

2. Within the 12 months prior to your departure date, have you: YES NO YES NO

(i) been prescribed **more than 3** separate and distinct prescription medications (excluding Aspirin) for the *treatment* of any one of the conditions listed above in **Table One**;

(ii) been prescribed **more than 4** separate and distinct prescription medications (excluding Aspirin) in total for all of the medical conditions listed above in **Table One**;

(iii) been recommended for heart, lung or gastrointestinal surgery, which has been postponed, delayed or refused by you or your physician(s);

(iv) had more than one episode of pneumonia;

(v) had an aneurysm larger than 3.5 centimeters, measured in either length or diameter, unless it has been surgically repaired;

(vi) had a lung condition which required the **daily** use of Prednisone for more than 180 consecutive days; .

(vii) been using Lasix/Furosemide **daily** for more than 30 consecutive days;

(viii) been diagnosed with or received *treatment* for congestive heart failure (CHF)?

3. Within the 24 months prior to your departure date, have you: YES NO YES NO

(i) been diagnosed with or *treated* for kidney or renal failure, required kidney dialysis, or had your physician suggest/recommend that you undergo kidney dialysis;

(ii) been diagnosed with a terminal illness;

(iii) been diagnosed with or *treated* for emphysema, cirrhosis of the liver or had 3 or more gastrointestinal bleeds;

(iv) been prescribed home oxygen?

4. Have you: YES NO YES NO

(i) had your most recent coronary by-pass or coronary angioplasty surgery (if any) more than 10 years prior to your departure date;.....

(ii) within the 5 years prior to your departure date, had 2 or more of the following procedures: coronary by-pass, coronary angioplasty, stenting, pacemaker insertion, or valve replacement(s) (2 procedures performed during the same surgery count as 1);

(iii) within the last 6 months, been told by a physician that you should postpone or not travel;

If you answered YES to any of the questions 1 through 4 above, you are not eligible to purchase this insurance. Other coverage options are available. Please contact us at 1-800-337-3532.

If you answered NO to questions in 1 through 4 above, please continue to Part 2 and Part 3 of this application.

IMPORTANT: If your health status changes prior to your policy effective date which makes you no longer eligible for this policy, you must notify Destination: Travel Health Plans immediately and upon submission of proof of ineligibility, will receive a full refund.

I have read the above eligibility questions. I understand them, and declare that all answers are correct. I acknowledge that any policy and coverage provided to me on the basis of the answers given will be deemed null and void if any answer is not correct.

X

 APPLICANT 1 SIGNATURE

X

 APPLICANT 2 SIGNATURE

Please base your rates on the plan classification you selected in Part 3 of Page 2

Single Trip Coverage: (Count both the Departure and Return Dates when determining the # of Travel Days)

Applicant 1 Departure Date (Policy Effective Date) DD MM YY Return Date (Policy Expiry Date) DD MM YY Daily Rate X # of Days = \$ _____ A1	Applicant 2 Departure Date (Policy Effective Date) DD MM YY Return Date (Policy Expiry Date) DD MM YY Daily Rate X # of Days = \$ _____ A2
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Annual / Multi-Trip Coverage:

Covers the first 8, 15, 30 or 60 days of any trip taken during the 365-day period from your policy effective date

Applicant 1 <input type="checkbox"/> 8 days <input type="checkbox"/> 15 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days Policy Effective Date DD MM YY Annual / Multi-Trip Premium = \$ _____ B1	Applicant 2 <input type="checkbox"/> 8 days <input type="checkbox"/> 15 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days Policy Effective Date DD MM YY Annual / Multi-Trip Premium = \$ _____ B2
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Top Up Coverage:

(Must be purchased BEFORE Departure. Extends other coverage or your **Destination: Travel Annual/Multi-Trip Plan.**)

Applicant 1 (Please be sure that the top-up policy effective date is the day after your other coverage expires.) Departure Date DD MM YY Top-up Policy Effective Date DD MM YY Return Date (Policy Expiry Date) DD MM YY Top-Up Trip Length: _____ Existing Coverage Name of Plan: _____ Insurance Company Name: _____ # of days of Existing Coverage: _____ Policy and/or Certificate number: _____	Applicant 2 Departure Date DD MM YY Top-up Policy Effective Date DD MM YY Return Date (Policy Expiry Date) DD MM YY Top-Up Trip Length: _____ Existing Coverage Name of Plan: _____ Insurance Company Name: _____ # of days of Existing Coverage: _____ Policy and/or Certificate number: _____
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Premium for Top-Up Coverage

Daily Rate X # of Days = \$ _____ C1	Daily Rate X # of Days = \$ _____ C2
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Part 5 – Premium Calculation Minimum Premium \$25.00 per Applicant

Applicant 1 Premium Subtotal A1 + B1 + C1 = \$ _____ P1 Have you used Tobacco products within 12 months prior to your departure date? <input type="checkbox"/> No <input type="checkbox"/> Yes + 10% If you answer "Yes" to the tobacco usage question above Multiply P1 by 1.10 = \$ _____ P3 If you apply with a companion you are eligible for a 5% Discount . To apply the companion discount, please Multiply P3 by 0.95 = \$ _____ P5	Applicant 2 Premium Subtotal A2 + B2 + C2 = \$ _____ P2 Have you used Tobacco products within 12 months prior to your departure date? <input type="checkbox"/> No <input type="checkbox"/> Yes + 10% If you answer "Yes" to the tobacco usage question above Multiply P2 by 1.10 = \$ _____ P4 If you apply with a companion you are eligible for a 5% Discount . To apply the companion discount, please Multiply P4 by 0.95 = \$ _____ P6
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All coverage is subject to a \$250 US deductible per incident of claim unless you choose otherwise.

To eliminate this deductible check the box below: \$0 – No Deductible Multiply P5 by 1.10 <input type="checkbox"/> To increase your deductible check the corresponding box below: \$500 US Multiply P5 by 0.95 <input type="checkbox"/> \$1,000 US Multiply P5 by 0.90 <input type="checkbox"/> \$5,000 US Multiply P5 by 0.70 <input type="checkbox"/> \$10,000 US Multiply P5 by 0.55 <input type="checkbox"/> Subtotal after adjustment for deductible = \$ _____ P7	To eliminate this deductible check the box below: \$0 – No Deductible Multiply P6 by 1.10 <input type="checkbox"/> To increase your deductible check the corresponding box below: \$500 US Multiply P6 by 0.95 <input type="checkbox"/> \$1,000 US Multiply P6 by 0.90 <input type="checkbox"/> \$5,000 US Multiply P6 by 0.70 <input type="checkbox"/> \$10,000 US Multiply P6 by 0.55 <input type="checkbox"/> Subtotal after adjustment for deductible = \$ _____ P8
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Total Premium Due P7 + P8 = \$ _____ P9 Minimum Premium \$25.00 per Applicant

Stable or stability: Means that my medical condition(s) is/are not worsening and there has been no alteration in any medication for the condition or in its usage or in its dosage, nor any alteration in *treatment* prescribed or recommended by a physician. The following are not considered alterations or changes in medications: the change from a brand named medication to a generic brand medication provided that the usage or dosage has not changed; a new medication prescribed solely as a result of a drug manufacturer's discontinuance of the original medication taken; the dosage changes of the regulatory medications insulin and coumadin; the dosage changes of thyroid and/or hormone medications; the decrease or elimination of a medication dosage by a physician, provided that it has changed more than 90 days prior to your policy effective date and has not had any effect on the *stability* of your medical condition for the 90 days prior to your policy effective date.

Treatment, treat or treated: Means a medical, therapeutic or diagnostic procedure prescribed, performed or recommended by a physician, including but not limited to prescribed medication, surgery or investigative testing that results in a diagnosis of a specific medical condition. Does not include *minor conditions*.

Minor Condition: Means an ailment which does not require any follow up consultation to any medical provider beyond one single assessment and includes the use of prescription medication for a maximum period of ten days, and which has not reoccurred in the six month period following the initial manifestation.

Part 7 - Payment Options

- Cheque Please make cheque payable to Destination: Travel Health Plans or your Broker
 Visa MasterCard

Cardholder's Name _____

Cardholder's Number _____ Expiry Date _____

Signature of Cardholder _____ MM / YY
(Only if different from applicant(s)) _____

Part 8 – Declaration and Authorization

- I declare that on my departure date(s), I will meet the eligibility and plan classification requirements. Where I was unsure of my medical condition(s), I consulted with my physician and I understand that only my physician or I can establish my eligibility for this policy. I understand that in applying for coverage under this policy it is my responsibility to be aware of all my medical conditions. I understand that no statement made by me or any agent prior to or at the time of my application for insurance will be considered valid unless such statement has been documented and submitted in writing and accepted by Destination: Travel Health Plans prior to the completion of this application. I understand the eligibility and plan classification requirements are material to the risk and form part of the application/policy and in consideration for the insurance for which I am applying.
- If I am found to be not eligible for this insurance, SelectCare Worldwide, on behalf of Co-operators Life Insurance Company has the right to collect from me any monies paid out on my behalf.
- I understand that the insurance applied for will not become effective unless Destination: Travel Health Plans / Co-operators Life Insurance Company accepts this application and receives the full premium and a signed and dated copy of the application. Destination: Travel Health Plans / Co-operators Life Insurance Company has the right to decline any application without explanation. In the event that this application is not accepted, I will receive a full refund. I understand that certain terms, conditions, limitations and exclusions will apply and that only *treatment* for medical emergencies will be covered under this insurance.
- Medical Authorization in Case of Claim – I understand that Co-operators Life Insurance Company and SelectCare Worldwide may investigate my claim. By signing this application, I hereby direct and authorize any physician, health care practitioner, hospital or other medical care facility, pharmacy, the Ministry of Health or any other person who has attended or examined me or who has knowledge or records of me or my health, to furnish to Destination: Travel Health Plans / Co-operators Life Insurance Company and to SelectCare Worldwide any or all information with respect to any illness, injury, medical history, consultations, medicines or *treatment* and copies of all hospital and/or medical records for the purpose of investigating my claim. Your personal information is also collected for the purpose of providing insurance services, claims analysis and payments. For Privacy information please see www.cooperatorstravelinsurance.ca.
- I hereby direct and authorize any other insurance plan under which I am covered for benefits to disclose personal information as may be necessary or to make payment in respect of my claim to Co-operators Life Insurance Company and SelectCare Worldwide directly.
- This authorization remains valid until any claim pending or disputed under a policy issued as a result of this application is settled unless an applicable law specifies a shorter period, in which case it would expire within the period applicable under that law.
- I/We the undersigned consent to Co-operators Life Insurance Company / SelectCare Worldwide providing Destination: Travel Health Plans with any and all data related to claims information.
- A photocopy, electronic copy or fax of this authorization will be treated in the same manner as the original.
- If I/we am/are paying for this insurance by credit card, I/we authorize this transaction.

Each Applicant Must Sign Below

Signature Applicant 1 _____

Signature Applicant 2 _____

Date of Application _____
DD / MM / YY

Broker Use Only

Broker ID 50000081

Broker Name McGill Financial Services