

## Detailed application and medical questionnaire

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### How to complete this form

Complete one form for each person applying for insurance.

#### 1 Complete the application

- answer all questions on the form
- if you're unsure about your answers, please talk to your physician first

#### 2 Make sure it's complete

This is an important form that will tell us whether or not we can insure you.

Make sure you:

- complete each section
- sign and date the form

If your application is missing information or isn't signed and dated, we'll have to follow up with you and it will take longer to process your application.

#### 3 Mail or fax it back to us

##### **TIC Travel Insurance Coordinators Ltd.**

Underwriting Department  
438 University Avenue, Suite 1200  
Toronto, Ontario M5G 2K8

**fax 1-866-256-2377 or  
416-340-0790**

If you have any questions about this form, you can reach us toll-free at:  
**1-888-298-8151**

Applicant's name (please print)

Date (mm/dd/yyyy)

**In this questionnaire, you and your mean the person to be insured.  
We, us and our mean TIC Travel Insurance Coordinators Ltd.**

Information about you

male  
 female

Last name (please print)

First name

Date of birth (mm/dd/yyyy)

Government health insurance #

Previous TIC policy #'s (if known)

**Your mailing address**

Street

Apt #

City

Province

Postal code

Phone

Fax

E-mail

**Who should we contact?**

you  
 your agent, or

Last name

First name

Phone

Fax

E-mail

Information about your agent

Bridges International Insurance Services

1345

Agency name

Agency code

Agent's name

604-408-8695

604-331-1042

info@biis.ca

Phone

Fax

E-mail

Details about your travel plans

Destination (city, state or country)

Departure date (mm/dd/yyyy)

Return date (mm/dd/yyyy)

**What type of coverage do you want?**

Single-trip

Visitor's insurance

Top-Up or Extension

Multi-trip

Global Expatriate

company name and policy number:

number of days per trip: \_\_\_\_\_

More details about you

**Height**

ft  in  
 cm

**Weight**

lbs  
 kg

Name of the last physician or medical clinic you visited

Phone number

Date you visited (mm/dd/yyyy)

Reason for visit

Results (medications prescribed, follow-up appointments, investigations or treatments, surgery recommended or scheduled)

Applicant's name (please print)

Date (mm/dd/yyyy)

General medical questions

1 Do you need help eating, bathing, using the toilet, changing positions, dressing or doing other daily tasks?

no yes - please provide details

2 Do you need to use a cane, walker, wheelchair or other mobility device?

no yes - please provide details

3 Have you been advised by a physician to have a test, investigation or surgery that you haven't had yet?

no yes - please provide details

4 In the last five years, have you been declined life, health or travel insurance or refused renewal of coverage?

no yes - please provide details

5 Have you smoked in the last 12 months?

no yes

Medications

Are you taking any prescription medications?

no yes - please tell us about your prescription medications below

Table with 4 columns: Name of medication, Condition being treated, Date first prescribed (mm/yyyy), Date of last dosage change (mm/yyyy). Includes checkboxes for increase/decrease.

Hospitalizations and surgery

Attach a separate sheet if necessary

Have you ever been hospitalized or had surgery?

no yes - please give details below

Table with 2 columns: Medical condition, Date (mm/yyyy). Includes checkboxes for hospitalization/surgery.

Don't include these unless they were in the last six months

- List of medical conditions: appendectomy, cataract removal, circumcision, dental repair or treatment, gall bladder removal, hernia repair, hysterectomy, normal or caesarean section childbirth, tonsillectomy, tubal ligation, vasectomy.

## Pre-existing medical conditions

## Check yes or no for each group of conditions

Check **yes** if you've **ever** had symptoms, investigations or treatment for any of the conditions in the group, then check the box beside the specific condition you have. If you have more than one condition, check the box for **every** condition that you have.

- 1 Heart and cardiovascular**
- no**
- yes** – please check all that apply
- arrhythmia or atrial fibrillation
  - heart murmur
  - chest pain or angina
  - arteriosclerosis
  - congestive heart failure
  - by-pass surgery
  - angioplasty or stent
  - use pacemaker or defibrillator
  - other: \_\_\_\_\_
- 2 Stroke and cerebrovascular**
- no**
- yes** – please check all that apply
- cerebrovascular accident (CVA)
  - stroke
  - transient ischemic attack (TIA) or mini-stroke
  - other: \_\_\_\_\_
- 3 Lung and respiratory**
- no**
- yes** – please check all that apply
- chronic obstructive pulmonary disease (COPD)
  - bronchial asthma
  - chronic bronchitis
  - emphysema
  - use of home oxygen
  - use of prednisone or cortisone
  - other: \_\_\_\_\_
- 4 Internal conditions**
- no**
- yes** – please check all that apply
- stomach or bowel disorder
  - peptic ulcer, diverticulitis, ulcerative colitis or Crohn's disease
  - liver disease
  - kidney dialysis
  - kidney disorder (including stones)
  - spleen or pancreatic disorder
  - prostate or urinary disorder
  - ovarian or uterine disorder
  - other: \_\_\_\_\_
- 5 Cancer**
- no**
- yes** – please check all that apply
- leukemia (specify type: \_\_\_\_\_ )
  - radiation treatment
  - chemotherapy
  - brachetherapy
  - hormone therapy
  - surgery
  - other: \_\_\_\_\_
- Is your cancer eliminated?
- no
- yes
- 6 Other conditions**
- no**
- yes** – please check all that apply
- aneurysm
    - heart
    - brain
    - abdominal aortic (AAA)
    - other
  - blood disorder (including hemophilia, sickle cell anemia, hemochromatosis)
  - neurological disorder (including Alzheimer's disease and dementia)
  - Parkinson's disease or seizures
  - diabetes – controlled by diet
  - diabetes – controlled by oral medication
  - diabetes – controlled by insulin
  - artery or vein disorder (including blood clots, carotid artery stenosis, peripheral vascular disease, deep vein thrombosis)
  - osteoporosis or osteopenia
  - high blood pressure
  - mental or nervous disorder or anxiety
  - other: \_\_\_\_\_

**Pre-existing medical condition**

Any sickness, injury or medical condition that has showed symptoms or required a *medical consultation* (even if the condition wasn't diagnosed), or that you've been treated, hospitalized or prescribed medication for.

A *medical consultation* includes services performed by a physician for an ailment, sickness or medical condition, which may include taking a history of the problem, examining you, advising or treating you, or ordering tests to confirm a diagnosis or find out more.

Please continue to the next page to tell us about symptoms, investigations and treatments. ►

Applicant's name (please print)

Date (mm/dd/yyyy)

Symptoms, investigations and treatments

Attach a separate sheet if necessary

Please tell us about the history of all the medical conditions you checked in the last section. We need to know about your symptoms, any investigations and treatments you've had, and any relevant dates.

Medical condition	Date (mm/yyyy)	Symptoms, investigations and treatments

Coverage requested

Do you want any of the pre-existing medical conditions you told us about in this questionnaire covered?

- no  yes – please list the conditions you'd like to have covered, in order of priority
- all my pre-existing medical conditions **or**  only the following conditions:

1	3
2	4

Declaration and authorization

Declaration

You declare that:

- the information you've provided in this application is truthful, complete and accurate.

You understand that:

- this application is part of a contract provided through TIC Travel Insurance Coordinators Ltd.
- if your medical status changes between the date you complete this application and your departure date or top-up/extension effective date, you must notify TIC Travel Insurance Coordinators Ltd. immediately or your coverage will be null and void, and

- TIC will collect, use, and/or disclose your personal information only to provide you with the insurance products and services you've requested, for other uses authorized by you, or as required by law.

You acknowledge that:

- if you misrepresent your medical status in this application or don't disclose material information about your medical status, your coverage will be null and void, your claims won't be paid and your premium will be refunded, and
- this coverage is subject to exclusions, terms, conditions and limitations that may limit or exclude an amount payable.

Authorization

You authorize:

- any organization or person that has records or knowledge of your health to give any and all information regarding your health, medical history and treatment to TIC Travel Insurance Coordinators Ltd. or its authorized representatives.

You understand and agree that:

- if you refuse or withdraw this authorization your application will be denied, and
- a copy of this authorization and declaration is as valid as the original.

Please sign here

You must sign and date this questionnaire or it will be returned to you.

If you made any corrections to your answers, please initial the corrections where they appear.

Your name (please print)

Signature

Date (mm/dd/yyyy)