

Detailed medical questionnaire

Underwritten by CUMIS General Insurance Company, a member of The Co-operators group of companies, and administered by Allianz Global Assistance. Allianz Global Assistance is a registered business name of AZGA Service Canada Inc.

How to complete this form: Complete one form for each person applying for insurance.

- Answer all questions on the form.
- If you're unsure about your answers, please talk to your physician first.
- Applicant, legal guardian or power of attorney must sign and date the form.
- If you have any questions about this form, you can reach us toll-free at: 1-888-298-8151.
- If your application is missing information or isn't signed and dated, we'll have to follow up with you or your agent/broker and it will take longer to process your application.

For the complete terms, conditions, limitations and exclusions please refer to the policy.

Mail, fax or email it back to us

AZGA Service Canada Inc.
o/a Allianz Global Assistance
 Underwriting Department
 P.O. Box 277
 Waterloo, Ontario N2J 4A4
 Canada

Fax: **1-866-256-2377** or 416-340-0790

Email: **directuw@allianz-assistance.ca**

Eligibility

1. Coverage is NOT AVAILABLE to any individual who, as of the effective date:

- has been diagnosed with a terminal illness; or
- has been diagnosed with stage 3 or 4 cancer; or
- has received treatment for any cancer (other than basal or squamous cell skin or breast cancer treated only with hormone therapy) in the past 3 months; or
- requires assistance with activities of daily living as the result of a medical condition or state of health.

You are eligible to apply for coverage if you meet the eligibility requirements stated.

Do you confirm that you are eligible to apply? NO YES


Information about you

Last name (please print)		First name	Date of birth <small>MM/DD/YYYY</small>	
Previous Allianz Global Assistance policy #'s (if known)				
Street		Apt #	City	
Province	Postal code	Phone	Fax	E-mail

Information about your agent – Only complete this section if you have an agent

Who should we contact? you your agent

Agent's name	Agent's code
Send correspondence by	
<input type="checkbox"/> Fax	<input type="checkbox"/> E-mail
Attention	

Ready to begin?
 Please go to the next page to get started. 

Applicant's name (please print) _____	MM/DD/YYYY Date _____
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Details about your travel plans

Destination (city, state or country) _____	MM/DD/YYYY Departure date _____	MM/DD/YYYY Return date _____
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What type of coverage do you want?

Visitors to Canada Plan

- \$10,000
 \$25,000
 \$50,000
 \$100,000
 \$150,000
 \$300,000

Your medical Information

- Have you smoked or used any tobacco products in the last 5 years? NO YES
- When was the last visit to your physician or medical clinic? (MM/DD/YYYY)

Height _____ ft/ in cm

Weight _____ lbs kg

Reason for visit/Results (diagnosis, medications prescribed, follow-up appointments, investigations or treatments, surgery recommended or scheduled)

- 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
-

Your 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.

Auto-immune disorder <input type="checkbox"/> NO <input type="checkbox"/> YES – please check all that apply <input type="checkbox"/> Lou Gehrig's disease	<input type="checkbox"/> scleroderma <input type="checkbox"/> acquired immune deficiency (AIDS) or human immunodeficiency virus (HIV) <input type="checkbox"/> multiple sclerosis	<input type="checkbox"/> systematic lupus erythematosus <input type="checkbox"/> sarcoidosis any location <input type="checkbox"/> myasthenia gravis <input type="checkbox"/> other _____
Blood disorder <input type="checkbox"/> NO <input type="checkbox"/> YES – please check all that apply <input type="checkbox"/> idiopathic thrombocytopenic purpura (ITP)	<input type="checkbox"/> hemochromatosis <input type="checkbox"/> sickle-cell anemia <input type="checkbox"/> anemia <input type="checkbox"/> thrombophilia (hypercoagulability)	<input type="checkbox"/> hemophilia (hypocoagulability) <input type="checkbox"/> spleen removed <input type="checkbox"/> other _____
High blood pressure, cholesterol or water retention <input type="checkbox"/> NO <input type="checkbox"/> YES – please check all that apply <input type="checkbox"/> high blood pressure <input type="checkbox"/> not taking medication	<input type="checkbox"/> taking medication <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3+ medications <input type="checkbox"/> high cholesterol <input type="checkbox"/> not taking medication <input type="checkbox"/> taking medication <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3+ medications	<input type="checkbox"/> treated for water retention or edema in the last 12 months <input type="checkbox"/> other _____

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



Applicant's name (please print)

Date

Diabetes NO YES – please check all that apply

- pre-diabetes
 diet-controlled diabetes

- type 1 diabetes (insulin)
 type 2 diabetes (oral medication)
 chronic kidney failure
 diabetic neuropathy
 skin infection (in last 30 days)

- lung infection (in last 30 days)
 diabetic retinopathy
 other _____

Blood Vessels NO YES – please check all that apply

- aneurysm
 ➤ repaired? NO YES
 ➤ location:
 abdominal brain
 thoracic heart

- atherosclerosis
 angina
 phlebitis (vein inflammation)
 peripheral vascular disease (PVD)
 deep vein thrombosis (DVT)
 thrombophlebitis

- varicose veins
 ➤ surgery? NO YES
 other _____

Lung Condition NO YES – please check all that apply

- chronic obstructive pulmonary disease (COPD)
 emphysema

- asthma
 no medication
 prednisone
 inhaler
 bronchitis
 3 or more episodes in last 24 months

- tuberculosis
 pulmonary fibrosis
 use of home oxygen
 lung transplant
 other _____

Heart NO YES – please check all that apply

- cardiomyopathy
 chest pain or angina
 prescribed and/or used any form of nitroglycerin (spray, patch, pill)
 heart attack
 ➤ How many have you had?
 1 2 3+
 cardiac or heart surgery
 heart transplant

- What type of surgery?
 balloon angioplasty
 stent angioplasty
 coronary artery bypass graft
 ➤ How many arteries were grafted?
 1 2 3 4
 3 or more bypass operations
 heart valve problem
 heart valve surgery
 balloon valvuloplasty
 stent valvuloplasty
 valve replacement

- irregular heart beat or rate (arrhythmia, bradycardia, tachycardia, atrial fibrillation, palpitations)
 on medication
 pacemaker inserted
 external defibrillator
 internal defibrillator
 ablation
 heart murmur
 congestive heart failure
 coronary artery disease
 other _____

Stroke / TIA NO YES – please check all that apply

- stroke
 ➤ How many have you had?
 1 2 3+

- require any assistance with activities of daily living
 transient ischemic attack (TIA) or mini-stroke
 ➤ How many have you had?
 1 2 3+
 endarterectomy (surgery on your carotid arteries)

- prescribed blood thinner (for example Warfarin, Coumadin)
 before stroke
 after stroke
 other _____

Muscle / Skeletal NO YES – please check all that apply

- arthritis
 rheumatoid arthritis

- osteoporosis, osteopenia
 degenerative disc disease (DDD)
 fibromyalgia
 herniated disc, spinal stenosis

- sciatica
 scoliosis
 spondylosis
 other _____

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

Applicant's name (please print)

Date

Stomach or bowel (intestine or colon) condition (including gallbladder, hernia, throat and liver) NO YES – please check all that apply**Gallbladder**

- gallbladder attack
 gallstones
 gallbladder removed

Bowel/intestine or colon

- celiac disease
 inflammatory bowel disease (Crohn's disease, ulcerative colitis)

- diverticulosis
 diverticulitis
 undiagnosed intestinal or rectal bleeding (not including hemorrhoids)
 irritable bowel syndrome (IBS)

Stomach

- gastric bypass surgery
 GERD, acid reflux or heartburn
 gastritis
 h. pylori
 hernia
 repaired? NO YES

- ulcer
 repaired? NO YES

Liver

- liver disease
 hepatitis A B C
 cirrhosis of the liver
 liver transplant

Throat

- scleroderma, dysphagia, incoordination or achalasia

Other _____**Kidney or urinary condition** NO YES – please check all that apply

- kidney failure
 kidney dialysis

- kidney transplant
 2 or more urinary infections in last 12 months
 protein in urine
 kidney cysts

- kidney / bladder stones
 How many times have you had stones? 1 2+
 other _____

Cancer NO YES – please check all that apply

➤ Location:

- brain breast bone
 bowel, colon, intestine
 Hodgkin's lymphoma
 kidney leukemia
 liver lung

- ovarian / cervical
 prostate bladder
 skin stomach
 throat
 other _____
 cancer has spread to other organs of the body
 inoperable in remission
 eliminated

- under treatment
 chemotherapy
 radiation treatment
 hormone replacement treatment
 surgery
 watchful waiting
 treatment is pending
 treatment declined
 other _____

Uterine fibroids, ovarian cysts or prostate NO YES – please check all that apply

- uterine fibroid
 surgery NO YES
 hysterectomy
 ovarian cyst
 surgery NO YES

- benign prostatic hypertrophy (BPH)
 on medication
 surgery
 other _____

Nervous system conditions NO YES – please check all that apply

- anxiety / emotional disorder
 Parkinson's disease
 Guillain-Barre syndrome

- epilepsy or seizures
 Alzheimer's disease
 travelling alone NO YES
 require any assistance with activities of daily living

- migraines
 other _____

Pregnancy

If you are female, are you currently pregnant?

 NO YES

If yes, what is your expected delivery date?

MM/DD/YYYY

Applicant's name (please print)	MM/DD/YYYY
	Date

Please tell us about the history of ALL your medical conditions you checked on page 2 and 3. We need to know about your symptoms, any investigations, treatments and prescriptions you've had. Attach a separate sheet if necessary.

Medical condition	Medication	Date prescribed	Last dosage change	Symptoms/investigation/treatment and date
		MM/DD/YYYY	MM/DD/YYYY	
		MM/DD/YYYY	MM/DD/YYYY	
		MM/DD/YYYY	MM/DD/YYYY	
		MM/DD/YYYY	MM/DD/YYYY	
		MM/DD/YYYY	MM/DD/YYYY	

Declaration

You declare that: The information you've provided in this questionnaire is truthful, complete and accurate.

You understand that:

- This questionnaire and the answers you provided are part of a contract provided through AZGA Service Canada Inc. o/a Allianz Global Assistance.
- If your medical status or any of your answers changes between the date you complete this questionnaire and your departure date or the effective date of any extension, you must contact Allianz Global Assistance prior to leaving on your trip to fully understand how your change in health affects the underwriting decision. Failure to do so may limit the amount of your claim payment or result in your claim being denied.
- The underwriting decision applies regardless of the sales medium and/or channel through which you purchase insurance. If a policy is issued to you that does not include this underwriting decision, it will be considered null and void, any premiums paid will be refunded

and no claims will be payable.

- Allianz Global Assistance 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 questionnaire, or if you don't disclose material information about your medical status, or if any of your answers are found to be incorrect or untrue, your coverage will be null and void, your claims won't be paid and your premium will be refunded, even if the material non-disclosure or inaccuracy is not related to the claim reported, and you will be solely responsible for all expenses related to your claim.

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 information¹ regarding your health, medical history and treatment to Allianz Global Assistance or its authorized representatives.

You understand and agree that:

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

I HAVE READ AND UNDERSTOOD THE IMPORTANT INFORMATION IN THE STATEMENT ABOVE NO YES

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

Applicant's name (please print)
MM/DD/YYYY
Date

Signature
MM/DD/YYYY
Signature date

¹ **IMPORTANT:** Information 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.

