



INSTRUCTIONS

These instructions have been designed for you to simplify the application process. **Read these instructions in full** before you begin. If you have any questions, please call Medipac for further assistance at **1-800-MEDIPAC** (1-800-633-4722).

Before you begin:

- Review your policy carefully **prior** to your departure; in particular, the “What is Not Covered” and the “General Limitations” sections. Certain exclusions and/or other limitations in benefits are applicable to your coverage.
- The policy contains stability period requirements which are applicable to any **new** and/or **pre-existing** medical conditions. If you do not meet the requirements of the stability period clauses, or you are ineligible for coverage, or have a change in health after your date of application and prior to your effective date of insurance, it is important that you call us; coverage may be available through our Individual Underwritten Insurance.
- If you are unclear about **any** of your medical conditions or medications, consult your doctor.

NOTE: Trips in excess of 183 days are available to residents of **all** provinces and territories **except** QC, PEI and NU.

Completing the Application:

- The application must be filled out in full and in **pen**.
- Your emergency contact should not be the person with whom you are travelling.
- All of the medical questions in sections A, C and D must be answered unless you are under the age of 56 and travelling for less than 41 days. Changes **must** be initialled by the applicant.
- An application cannot be processed without specific departure and return dates. If you are unsure of your dates, select the dates and trip length that are closest to your estimated travel time period. When you have finalized your travel plans, call us before your departure date

for your **free** policy change (*if your trip length changes, a premium adjustment may be required*).

- Your application must be **signed and dated** by both applicants (if applicable). Be sure that you **read and understand** section H. DECLARATION/AUTHORIZATION.

Skipping any of the above steps will require correction and will delay processing of your application.

Important reminders:

- You **must** have a policy number before you leave for your trip.
- If you have **any change in health** after the date you completed your application and prior to your effective date of insurance, you **must** call Medipac.
- Prior to seeking medical attention **you must call Medipac Assist**. Failure to call will result in benefits being limited (*see policy wording included*). If you are experiencing a medical emergency, call 911 first. As with all travel insurance plans, in the event of a claim, your medical records **will** be reviewed.
- Change in plans? If you are leaving before or after your original effective date you **must** notify Medipac in advance to change your dates, or your coverage will be limited.
- Staying longer than expected? Call Medipac for an extension of coverage. Extensions **must** be applied for prior to your expiry date. (*see policy extension wording included*).
- Need to cancel or coming home early? *See policy refund wording included*.



CHECKLIST

Before you submit your application, ensure that:

- ☐ All medical questions have been answered and any changes made to the application have been initialled by the individual applying for insurance.
- ☐ You have indicated your departure and return dates, trip length and deductible.
- ☐ Each applicant has signed and dated section H with the date the application was actually signed.
- ☐ Your payment is included. *Full payment must be received prior to departure, or your policy will not be valid. NSF's will be charged \$25.*

To Pay In Full:

- Include a cheque payable to Medipac Travel Insurance or complete the credit card information in section I.

To Pay by Instalments (only available with a departure date after October 15):

- Include one cheque marked VOID or complete section I for credit card instalments. Note: post-dated cheques are not required.
- Payment by instalments will be taken on the date your application is processed, August 15, September 15 and October 15.
- If your credit card expires before any of the instalment dates, call us with the new expiry date when your new card arrives.
- If paying by instalments and your application is processed after any of the instalment dates, missed payment(s) will be combined and included on the next instalment date. This means multiple payments will be taken at once.

Application must be postmarked on or before August 31, 2025.





MEDIPAC

TRAVEL EMERGENCY MEDICAL INSURANCE APPLICATION

2025 EARLY BIRD PLAN – APPLICATIONS MUST BE POSTMARKED ON OR BEFORE AUGUST 31

If you are travelling for less than 41 days and you are under the age of 56, you do not have to complete sections A, C and D of this application.
If you are uncertain of your answer to any of the medical questions, consult your doctor.

A. ELIGIBILITY

		APPLICANT 1 YES NO	APPLICANT 2 YES NO
1	Have you been diagnosed as having a terminal illness or have you been advised by a physician not to travel?	1 <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	Have you been diagnosed with pulmonary fibrosis or interstitial lung disease?	2 <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3	Have you EVER had an organ or bone marrow transplant (excluding cornea or skin graft) or a blood disorder for which you have received stem cell treatment?	3 <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
4	During the 5 YEARS prior to the date of this application, have you been treated for, taken or been prescribed medication for, or been diagnosed with lung cancer, metastatic cancer or two (2) or more cancers (excluding basal cell and squamous cell skin cancer)?	4 <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
5	Do you HAVE a cardiac condition with an ejection fraction of LESS THAN 41% or a ventricular function grade of 3 or 4?	5 <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
6	Do you HAVE moderately severe or severe cardiac valve stenosis?	6 <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
7	Do you HAVE an aneurysm or dilated artery greater than 4.5 cm in size (diameter or width) which remains surgically untreated?	7 <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
8	During the 6 MONTHS prior to the date of this application, have you:		
	a undergone chemotherapy, immunotherapy or targeted drug therapy for cancer or malignant tumour(s)?	8a <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	b had surgery or stenting on ANY artery or cardiac pacemaker implant surgery?	8b <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
9	During the 12 MONTHS prior to the date of this application have you:		
	a had cardiac ablation, cardiac defibrillator implant surgery, coronary angioplasty and/or stent, coronary bypass surgery, cardiac valve replacement or repair, had a heart attack, a cardiac arrest or an episode of congestive heart failure?	9a <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	b had a stroke, a transient ischemic attack (TIA) or a ministroke?	9b <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	c had ANY chronic lung disease (including emphysema, chronic obstructive pulmonary disease [COPD], chronic bronchitis, reactive airway disease or asthma) which caused you to be hospitalized for more than 24 consecutive hours, or for which you have taken or been prescribed prednisone or Solu-Medrol?	9c <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	d taken or been prescribed home oxygen for any reason?	9d <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	e taken or been prescribed insulin or two (2) or more medications for diabetes AND medication for a heart condition? <i>If medication is taken or prescribed for only one condition, answer "No" to this question.</i> The term "medication" includes nitroglycerin in any form. Hypertension (high blood pressure) is not considered a heart condition.	9e <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO



IF YOU ANSWERED YES TO ANY QUESTION ABOVE, YOU ARE NOT ELIGIBLE.
Call us, we can help. 1-877-888-5259.



IF YOU ANSWERED NO TO ALL QUESTIONS ABOVE, YOU ARE ELIGIBLE.
Continue your application.

B. PERSONAL INFORMATION

Please Print

APPLICANT 1				APPLICANT 2			
First and Last Name:				First and Last Name:			
Date of Birth: Day: _____ Month: _____ Year: _____		Male <input type="checkbox"/> Female <input type="checkbox"/>		Date of Birth: Day: _____ Month: _____ Year: _____		Male <input type="checkbox"/> Female <input type="checkbox"/>	
Have you smoked cigarettes or used vaping products (including e-cigarettes) in the 2 years prior to the date of this application? Yes <input type="checkbox"/> No <input type="checkbox"/>				Have you smoked cigarettes or used vaping products (including e-cigarettes) in the 2 years prior to the date of this application? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Doctor's Name:		Phone: ()		Doctor's Name:		Phone: ()	
Specialist's Name (if any):		Phone: ()		Specialist's Name (if any):		Phone: ()	
Specialty Type:				Specialty Type:			
Emergency Contact Person not travelling with you:		Phone: ()		Emergency Contact Person not travelling with you:		Phone: ()	
CANADIAN ADDRESS (Both Applicants)				OUT-OF-COUNTRY ADDRESS (Both Applicants, if applicable)			
Street Name & Number:		Apt # or Lot #:		Street Name & Number:		Apt # or Lot #:	
City:	Province:	Postal Code:		City:	State:	Zip Code:	
E-mail:				E-mail:			
Phone: ()		Cell: ()		Phone: ()		Cell: ()	
Please send my insurance policy to my (check one): <input type="checkbox"/> Email Address <input type="checkbox"/> Canadian Address <input type="checkbox"/> Out-of-Country Address							

C. RATE QUALIFICATION - PART 1			APPLICANT 1 YES NO	APPLICANT 2 YES NO
1	Have you EVER had congestive heart failure or heart surgery of ANY kind (including cardiac ablation, cardiac pacemaker/defibrillator implant, coronary angioplasty and/or stent, coronary bypass surgery, cardiac valve replacement or repair)?	1	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	During the 5 YEARS prior to the date of this application, have you been treated for, taken or been prescribed medication for, or been diagnosed with:			
	a ANY heart condition (including atrial fibrillation, irregular heart beat, angina or heart attack), narrowing or blockage of ANY artery (including pulmonary embolism [PE], peripheral artery disease [PAD] or carotid stenosis), or pulmonary hypertension?	2a	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	b chronic lung disease (including emphysema, chronic obstructive pulmonary disease [COPD] or chronic bronchitis)?	2b	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	c a stroke, a transient ischemic attack (TIA), a ministroke or amaurosis fugax (excluding treatment with aspirin)?	2c	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3	During the 3 YEARS prior to the date of this application, have you been treated for, taken or been prescribed medication for, or been diagnosed with chronic bowel disease or disorder (including colitis, Crohn's disease, diverticulitis or irritable bowel syndrome), pancreatitis or gastrointestinal bleeding?	3	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
4	During the 12 MONTHS prior to the date of this application, have you been treated for, taken or been prescribed medication for, or been diagnosed with cancer or malignant tumour(s) (excluding basal cell and squamous cell skin cancer)? The term "medication" excludes tamoxifen and ANY other hormone treatment.	4	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
5	During the 12 MONTHS prior to the date of this application, have you taken or been prescribed two (2) or more inhalers (including a rescue inhaler)?	5	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
6	During the 3 MONTHS prior to the date of this application, have you taken or been prescribed:			
	a corticosteroids (including prednisone and Solu-Medrol) for more than 15 days (excluding inhalers, topical medications and eye drops)?	6a	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	b a total of 3 or more medications for diabetes (including glucose intolerance), hypertension (high blood pressure) or a combination of both conditions? The term "medication" includes diuretics (water pills).	6b	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
7	Have you been diagnosed with Lou Gehrig's disease (ALS), muscular dystrophy, myasthenia gravis, cerebral palsy, multiple sclerosis or dementia (including Alzheimer's disease)?	7	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
8	Do you HAVE reduced kidney function with an eGFR of less than 45 or cirrhosis of the liver?	8	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
9	Do you HAVE diabetes requiring insulin?	9	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

D. RATE QUALIFICATION - PART 2			APPLICANT 1 YES NO	APPLICANT 2 YES NO
1	Have you EVER had narrowing or blockage of ANY artery (including pulmonary embolism [PE], peripheral artery disease [PAD] or carotid stenosis), an aneurysm, pulmonary hypertension, or ANY heart condition (including atrial fibrillation, irregular heart beat, a heart attack or angina)?	1	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	Have you EVER had a stroke, a transient ischemic attack (TIA) or a ministroke?	2	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3	Do you HAVE diabetes (including glucose intolerance) requiring medication?	3	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
4	During the 2 YEARS prior to the date of this application, have you been treated for, taken or been prescribed medication for, or been diagnosed with:			
	a a blood disorder by an Internist or a Hematologist?	4a	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	b epilepsy or any other seizure disorder (including an untreated episode)?	4b	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	c Parkinson's disease or Parkinson's syndrome?	4c	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
5	During the 12 MONTHS prior to the date of this application, have you had a fainting spell or a syncopal episode?	5	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
6	During the 3 MONTHS prior to the date of this application, have you taken or been prescribed:			
	a anticoagulants (blood thinners) or antiplatelets (excluding aspirin)?	6a	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	b Lasix or furosemide?	6b	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
7	During the 3 MONTHS prior to the date of this application, have you been treated for, taken or been prescribed medication for, or been diagnosed with an autoimmune condition? The term "medication" includes targeted immunotherapies, disease modifying antirheumatics, and/or immunosuppressants (excluding methotrexate).	7	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

WHICH PLAN DO YOU QUALIFY FOR?		
If you answered NO to ALL of the questions in section C and D,	If you answered NO to ALL of the questions in section C but YES to ANY of the questions in section D,	If you answered YES to ANY of the questions in section C,
YOU QUALIFY FOR THE PREFERRED PLUS PLAN	YOU QUALIFY FOR THE PREFERRED PLAN	YOU QUALIFY FOR THE STANDARD PLAN



NEED HELP? Call 1-800-MEDIPAC
 1-800-633-4722 • (416) 441-7070 in the GTA • Fax # (416) 441-7030
 Medipac Travel Insurance, 180 Lesmill Road, Toronto, ON M3B 2T5 • www.medipac.com

Underwritten by
Old Republic Insurance Company of Canada
 Administered by Medipac International Inc.

E. TRAVEL INFORMATION

If you are taking multiple trips, provide details on a separate piece of paper.

SINGLE TRIP DETAILS

APPLICANT 1

APPLICANT 2

Must be completed even if topping up.

Date of Departure:Day:Month:Year:

Date of Departure:Day:Month:Year:

Scheduled Return Date:Day:Month:Year:

Scheduled Return Date:Day:Month:Year:

OTHER INSURANCE COVERAGE

If you have other Insurance with similar out-of-country benefits, provide details. Must be completed if topping up, or applying for Federal Superannuate Credit.

I am a Superannuate and I request that my policy be issued with a deductible of \$1,000,000 CAD for the first 40 days of my trip.

I am a Superannuate and I request that my policy be issued with a deductible of \$1,000,000 CAD for the first 40 days of my trip.

I am topping up my other insurance and request that my Medipac Effective Date be: Day:Month:Year:

I am topping up my other insurance and request that my Medipac Effective Date be: Day:Month:Year:

Name of Plan:Insurance Company:Policy #:Number of days covered:Single CoverageFamily CoverageCertificate #

Name of Plan:Insurance Company:Policy #:Number of days covered:Single CoverageFamily CoverageCertificate #

NUMBER OF DAYS APPLIED FOR

See rate tables for trip lengths.

3691215182124273033364050606675829096105112120126135142150156165175183190200212

3691215182124273033364050606675829096105112120126135142150156165175183190200212

ANNUAL ADD-ON

(Optional)

See page 12 of the guide for details.

Add Annual Add-on:23-day33-day

Add Annual Add-on:23-day33-day

A. to start on my Effective Date of Insurance, OR

A. to start on my Effective Date of Insurance, OR

B. to start on Day:Month:Year:

B. to start on Day:Month:Year:

For Option B, this date must be between the date your application is processed and your Effective Date of Insurance. You must buy a minimum 22-24 day trip to purchase the 23-day Annual Add-on or a minimum 31-33 day trip to purchase the 33-day Annual Add-on.

MedipacMAX / MedipacPLUS

(Select Coverage)

See page 13 of the guide for details.

YESAdd MedipacMAXAdd MedipacPLUS

YESAdd MedipacMAXAdd MedipacPLUS

F. PREMIUM CALCULATION

Rate Category:Preferred PLUSPreferredStandard

Rate Category:Preferred PLUSPreferredStandard

Select USD Deductible:\$0\$99\$1,000\$5,000\$10,000

Select USD Deductible:\$0\$99\$1,000\$5,000\$10,000

Age at Departure:

Age at Departure:

Single Trip Rate for Applicant 1:

Single Trip Rate for Applicant 2:

SUBTRACT Total discount() %

SUBTRACT Total discount() %

ADD Annual Add-on Rate (if applicable):

ADD Annual Add-on Rate (if applicable):

Rate Subtotal:

Rate Subtotal:

ADD 10% for a \$0 Deductible:

ADD 10% for a \$0 Deductible:

Subtotal:

Subtotal:

ADD 20% if you have smoked cigarettes or used vaping products in the 2 years prior to the date of this application:

ADD 20% if you have smoked cigarettes or used vaping products in the 2 years prior to the date of this application:

SUBTRACT Federal Superannuate Credit (if applicable):

SUBTRACT Federal Superannuate Credit (if applicable):

ADD \$147 for MedipacMAX (recommended) or \$59 for MedipacPLUS:

ADD \$147 for MedipacMAX (recommended) or \$59 for MedipacPLUS:

Total Premium for Applicant 1:

Total Premium for Applicant 2:

G. PAYMENT OPTION

Premiums are in Canadian dollars

OPTION 1: Pay in Full.

OPTION 2: Pay by Instalments. See instructions for details.

Make your cheque payable to Medipac Travel Insurance or fill out the credit card information in section I.

Include a void cheque or fill out the credit card information in section I.

Do NOT write in this area.

NOTES: _____

This application must be completed in full, dated, and signed within Canada prior to departure. Medipac reserves the right to refuse any application.

I, the undersigned, understand that obtaining travel emergency medical insurance coverage under the policy is dependent on the accuracy of the information that I provide in this application. **I acknowledge that** it is my responsibility to be fully aware of my medical history, and that **I am advised** to consult with my doctor(s) and have had the opportunity to verify the accuracy of the information which I provide herein.

IMPORTANT NOTICE: All answers in this application must be and remain true up to and including the Effective Date of Insurance. **Should my health change** in any way (including any new or changed diagnosis) and/or should I have any investigations or seek medical attention between the date of this application and the Effective Date of Insurance, **I agree** to promptly notify Medipac International Inc. (Medipac). Medipac will reassess my eligibility and may adjust my premium accordingly. Failure to update Medipac may result in limited coverage, a claim denied and/or the policy deemed **null and void**.

I understand that in the event that I experience a medical emergency, seek medical attention and/or submit a claim under the policy, my medical records may be required and reviewed. **I understand that if** it is determined that any information I provide is misleading, is contrary to my medical records, or is inaccurate, coverage may be limited, a claim denied and/or the policy deemed **null and void**.

I **acknowledge** having received a copy of this application and the policy. Furthermore, I **affirm that** I have read, understand, and agree to the terms and conditions of the policy, including the General Exclusions, General Limitations and those related to Unstable Pre-existing Conditions; including, among other things, any medical conditions **1) that were NOT stated and controlled**, including any reaction to a change in medication, during the 90 days prior to my requested Effective Date of Insurance (or any Trip Start Date under the Annual Add-on); **or 2) which required** a total of three [3] or more emergency room visits, hospitalizations, day surgeries or any combination of all three, **and/or** a single hospitalization for more than 48 consecutive hours, in the 12 months prior to my requested Effective Date of Insurance (or any Trip Start Date under the Annual Add-on); **or 3) for which treatment** and/or investigation(s) were recommended but not received prior to my requested Effective Date of Insurance (or any Trip Start Date under the Annual Add-on).

I acknowledge and agree that by submitting this application, access to and use of my personal information will be governed by both Medipac's Privacy Policy, available at www.medipac.com/privacy-policy, and Old Republic Insurance Company of Canada's (the Company) NOTICE ON PRIVACY, available at www.orican.com/privacy.

In the event I experience a medical emergency, seek medical attention or submit a claim. **I hereby authorize** any physician, practitioner, health-care provider, hospital, health-care institution, medical organization, clinic and any other medical or medically related facility, insurance company, Workers' Compensation Board or similar plan or organization and any Ministry of Health to release and exchange with Medipac, Medipac Assist and the Company, or representatives thereof, my complete medical records, including medical treatment provided by my primary care physician and treatment I received, am about to receive or may receive in the future. I authorize the period of 12 months from the date of my notice of claim as the period of access to, and disclosure of, my individually identifiable health information in accordance with the Canadian PIPEDA (Personal Information Protection and Electronic Documents Act) and U.S. HIPAA (Health Insurance Portability and Accountability Act) Privacy Practices. A photocopy or electronic copy of this authorization shall be as valid as the original.

In the event of a claim, where applicable, I authorize that my deductible be charged to the credit card number used to purchase the policy. If expenses are less than the deductible, a refund will be issued.



X

Applicant 2 - print name in full



Date Signed: Day _____ **Month** _____ **Year** _____

Canadian dollar account ONLY

Cardholder Name:															<input type="checkbox"/> Visa					<input type="checkbox"/> MasterCard				
Card #:															Expiry Date									
															Month:					Year:				