



# MEDIPAC TRAVEL EMERGENCY MEDICAL INSURANCE APPLICATION 2011-2012

If you are travelling for less than 41 days and you are under the age of 61, 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		APPLICANT 2	
			YES	NO	YES	NO
1	Have you been diagnosed as having a terminal illness, been advised by a physician not to travel or do you have HIV, AIDS or AIDS-related complex?	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?	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)?	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 or Metastatic 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 40% 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 greater than 4.0 cm in size (diameter, width or length) 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 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 Cardiac Pacemaker Implant surgery, Coronary Bypass surgery or surgery on ANY artery?	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 any other Heart surgery (including Cardiac Defibrillator Implant, Angioplasty and/or Stent), had a Heart Attack 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 or 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 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 oral medications for Diabetes AND medication for a heart condition? The term "medication" includes Nitroglycerin in any form. If medication is taken or prescribed for only one condition, answer "No" to this question.	9e	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO



If you answered YES to ANY of the questions in Section A, YOU ARE NOT ELIGIBLE to purchase this plan. Call about our Personalized Insurance Plan.



If you answered NO to ALL the questions in Section A, YOU ARE ELIGIBLE to purchase this plan. Please complete the application.

B. PERSONAL INFORMATION				Please Print			
APPLICANT 1				APPLICANT 2			
Name:				Name:			
Date of Birth: (DD/MM/YYYY)		Male <input type="checkbox"/> Female <input type="checkbox"/>		Date of Birth: (DD/MM/YYYY)		Male <input type="checkbox"/> Female <input type="checkbox"/>	
Provincial Health Card #:		Version Code: If Any (ON Only)		Provincial Health Card #:		Version Code: If Any (ON Only)	
Pre-retirement employer:		Position:		Pre-retirement employer:		Position:	
Have you smoked cigarettes in the 3 years prior to the date of this application? <input type="checkbox"/> YES <input type="checkbox"/> NO				Have you smoked cigarettes in the 3 years prior to the date of this application? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Doctor's Name:		Phone: ( )		Doctor's Name:		Phone: ( )	
Specialist's Name:		Phone: ( )		Specialist's Name:		Phone: ( )	
Specialty Type:				Specialty Type:			
Emergency Contact:		Phone: ( )		Emergency Contact:		Phone: ( )	

CANADIAN ADDRESS (Both Applicants)				OUT-OF-COUNTRY ADDRESS (Both Applicants)			
				<input type="checkbox"/> Permanent Address <input type="checkbox"/> Temporary Address			
Street Name & Number:		Apt # or Lot #:		Street Name & Number:		Apt # or Lot #:	
City:	Province:	Postal Code:		City:	State:	Zip Code:	
E-mail:		Phone: ( )		E-mail:		Phone: ( )	
Please mail my insurance policy to my: <input type="checkbox"/> Canadian Address				<input type="checkbox"/> Out-of-Country Address			

<b>C. RATE QUALIFICATION - Part 1</b>			APPLICANT 1 YES NO	APPLICANT 2 YES NO
1	<b>Have you EVER</b> had Congestive Heart Failure or Heart surgery of <b>ANY</b> kind ( <b>including</b> Coronary Bypass, Cardiac Pacemaker Implant, Cardiac Defibrillator Implant, Angioplasty and/or Stent)?	1	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	<b>During the 5 YEARS</b> prior to the date of this application, have you been treated for, taken or been prescribed medication for, or been diagnosed with:			
	(a) Narrowing or blockage of <b>ANY</b> Artery ( <b>including</b> Peripheral Vascular Disease [PVD]), an Aneurysm, a Heart Attack, <b>ANY</b> Heart Condition ( <b>including</b> Atrial Fibrillation or Irregular Heartbeat) or Angina? The term "medication" includes Nitroglycerin in any form.	2a	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	(b) Chronic Lung Disease <b>including</b> 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) Stroke or Transient Ischemic Attack (TIA) or Ministroke ( <b>excluding</b> treatment with aspirin)?	2c	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3	<b>During the 2 YEARS</b> prior to the date of this application, have you been treated for, taken or been prescribed medication for, or been diagnosed with:			
	(a) Chronic Bowel Disease or Disorder ( <b>including</b> Diverticulitis or Irritable Bowel Syndrome), Pancreatitis or Gastrointestinal Bleeding?	3a	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	(b) Asthma for which you have taken or been prescribed Prednisone, Solu-Medrol or two (2) or more inhalers?	3b	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
4	<b>During the 12 MONTHS</b> 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 Tumours ( <b>excluding</b> Basal Cell and Squamous Cell Skin Cancer)? The term "medication" <b>excludes</b> Tamoxifen and <b>ANY</b> other Hormone Treatment.	4	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
5	<b>During the 3 MONTHS</b> prior to the date of this application have you taken or been prescribed:			
	(a) Prednisone or Solu-Medrol ( <b>excluding</b> inhalers)?	5a	<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 ( <b>including</b> Glucose Intolerance), Hypertension (High Blood Pressure) or both? The term "medication" includes diuretics (water pills).	5b	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
6	<b>Have you been diagnosed with</b> Lou Gehrig's Disease (ALS), Muscular Dystrophy, Myasthenia Gravis, Cerebral Palsy, Multiple Sclerosis or Dementia ( <b>including</b> Alzheimer's Disease)?	6	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
7	<b>Do you HAVE</b> Cirrhosis of the Liver, or moderate or severe Kidney failure?	7	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
8	<b>Do you HAVE</b> Diabetes requiring Insulin?	8	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

<b>D. RATE QUALIFICATION - Part 2</b>			APPLICANT 1 YES NO	APPLICANT 2 YES NO
1	<b>Have you EVER</b> had narrowing or blockage of <b>ANY</b> Artery, ( <b>including</b> Peripheral Vascular Disease [PVD]), an Aneurysm, a Heart Attack, <b>ANY</b> Heart Condition ( <b>including</b> Atrial Fibrillation or Irregular Heartbeat) or Angina?	1	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	<b>Have you EVER</b> had a Stroke or Transient Ischemic Attack (TIA) or Ministroke?	2	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3	<b>Do you HAVE</b> Diabetes ( <b>including</b> Glucose Intolerance) requiring oral medication?	3	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
4	<b>During the 2 YEARS</b> 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 ( <b>including</b> an untreated episode)?	4b	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	(c) Parkinson's Disease?	4c	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	(d) Transient Global Amnesia?	4d	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
5	<b>During the 12 MONTHS</b> 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	<b>During the 3 MONTHS</b> prior to the date of this application have you taken or been prescribed:			
	(a) Lasix or Furosemide?	6a	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	(b) any Immunosuppressive Drugs ( <b>excluding</b> Methotrexate)?	6b	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

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



**NEED HELP? Call 1-888-MEDIPAC!**  
 1-888-633-4722 • (416) 441-7070 in the GTA • Fax # (416) 441-7030  
 Medipac International Inc., 180 Lesmill Road, Toronto, ON M3B 2T5 • www.medipac.com

**Manulife Financial**  
 For your future™

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## E. TRAVEL INFORMATION

APPLICANT 1	OTHER INSURANCE COVERAGE	APPLICANT 2
<i>If you have other Insurance with similar Out-of-Country Extended Health Benefits, please provide details below. Must be completed if topping up, or applying for Federal Superannuate Credit.</i>		
Name of Plan:	Number of days covered:	Name of Plan:
Insurance Company:	<input type="checkbox"/> Single Coverage <input type="checkbox"/> Family Coverage	Insurance Company:
Policy #:	Certificate #	Policy #:
<input type="checkbox"/> I am a <b>Superannuate</b> and I request that my policy be issued with a deductible of CDN\$500,000 for the first 40 days of my trip.		<input type="checkbox"/> I am a <b>Superannuate</b> and I request that my policy be issued with a deductible of CDN\$500,000 for the first 40 days of my trip.
<input type="checkbox"/> I request my policy be issued with a deductible of CDN\$100,000 for the first 40 days of my trip.		<input type="checkbox"/> I request my policy be issued with a deductible of CDN\$100,000 for the first 40 days of my trip.
<input type="checkbox"/> I am <b>topping up</b> my other insurance and request an Effective Date of Insurance of: Day: ____ Month: ____ Year: ____		<input type="checkbox"/> I am <b>topping up</b> my other insurance and request an Effective Date of Insurance of: Day: ____ Month: ____ Year: ____

### SINGLE TRIP PLAN

Date of Departure: Day: ____ Month: ____ Year: ____	<input type="checkbox"/> Same as applicant 1 Date of Departure: Day: ____ Month: ____ Year: ____																																																																				
Scheduled Return Date: Day: ____ Month: ____ Year: ____	Scheduled Return Date: Day: ____ Month: ____ Year: ____																																																																				
<b>Trip Length Applied for :</b>	<b>Trip Length Applied for :</b>																																																																				
<table border="1" style="font-size: small; border-collapse: collapse; width: 100%;"> <tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td><td>18</td><td>21</td><td>24</td><td>27</td><td>30</td><td>33</td><td>36</td><td>40</td><td>50</td><td>60</td><td>66</td><td>75</td></tr> <tr><td>82</td><td>90</td><td>96</td><td>105</td><td>112</td><td>120</td><td>126</td><td>135</td><td>142</td><td>150</td><td>156</td><td>165</td><td>175</td><td>183</td><td>190</td><td>200</td><td>212</td></tr> </table>	3	6	9	12	15	18	21	24	27	30	33	36	40	50	60	66	75	82	90	96	105	112	120	126	135	142	150	156	165	175	183	190	200	212	<table border="1" style="font-size: small; border-collapse: collapse; width: 100%;"> <tr><td>3</td><td>6</td><td>9</td><td>12</td><td>15</td><td>18</td><td>21</td><td>24</td><td>27</td><td>30</td><td>33</td><td>36</td><td>40</td><td>50</td><td>60</td><td>66</td><td>75</td></tr> <tr><td>82</td><td>90</td><td>96</td><td>105</td><td>112</td><td>120</td><td>126</td><td>135</td><td>142</td><td>150</td><td>156</td><td>165</td><td>175</td><td>183</td><td>190</td><td>200</td><td>212</td></tr> </table>	3	6	9	12	15	18	21	24	27	30	33	36	40	50	60	66	75	82	90	96	105	112	120	126	135	142	150	156	165	175	183	190	200	212
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### ANNUAL ADD-ON

*Available only if you purchased a single trip plan of 22 days or longer.*

<input type="checkbox"/> I am applying for the Annual Add-on and wish for it to begin on:	<input type="checkbox"/> I am applying for the Annual Add-on and wish for it to begin on:
<input type="checkbox"/> A. the date my application is processed.	<input type="checkbox"/> A. the date my application is processed.
<input type="checkbox"/> B. my Effective Date of Insurance.	<input type="checkbox"/> B. my Effective Date of Insurance.
<input type="checkbox"/> C. ____ / ____ / ____ (dd/mm/yyyy)	<input type="checkbox"/> C. ____ / ____ / ____ (dd/mm/yyyy)
<i>For Option C, this date must be between the date your application is processed and your Effective Date of Insurance.</i>	

## F. PREMIUM CALCULATION

Rate Category:	<input type="checkbox"/> Preferred PLUS	<input type="checkbox"/> Preferred	<input type="checkbox"/> Standard	Rate Category:	<input type="checkbox"/> Preferred PLUS	<input type="checkbox"/> Preferred	<input type="checkbox"/> Standard
<b>Select USD Deductible:</b>	<input type="checkbox"/> \$ 0 <input type="checkbox"/> \$ 99 <input type="checkbox"/> \$ 1,000 <input type="checkbox"/> \$ 5,000 <input type="checkbox"/> \$ 10,000	<input type="checkbox"/> \$ 0 <input type="checkbox"/> \$ 250 <input type="checkbox"/> \$ 1,000 <input type="checkbox"/> \$ 5,000 <input type="checkbox"/> \$ 10,000	<input type="checkbox"/> \$ 0 <input type="checkbox"/> \$ 250 <input type="checkbox"/> \$ 1,000 <input type="checkbox"/> \$ 5,000 <input type="checkbox"/> \$ 10,000	<b>Select USD Deductible:</b>	<input type="checkbox"/> \$ 0 <input type="checkbox"/> \$ 99 <input type="checkbox"/> \$ 1,000 <input type="checkbox"/> \$ 5,000 <input type="checkbox"/> \$ 10,000	<input type="checkbox"/> \$ 0 <input type="checkbox"/> \$ 250 <input type="checkbox"/> \$ 1,000 <input type="checkbox"/> \$ 5,000 <input type="checkbox"/> \$ 10,000	<input type="checkbox"/> \$ 0 <input type="checkbox"/> \$ 250 <input type="checkbox"/> \$ 1,000 <input type="checkbox"/> \$ 5,000 <input type="checkbox"/> \$ 10,000
Discount Authorization Code:	Age at Departure:		Discount Authorization Code:	Age at Departure:			
Single Trip Rate for Applicant 1:			Single Trip Rate for Applicant 2:				
<b>SUBTRACT</b> Total discount: ( ____ ) %	-		<b>SUBTRACT</b> Total discount: ( ____ ) %	-			
<b>Subtotal:</b>	=		<b>Subtotal:</b>	=			
<b>ADD Annual Add-on Rate (if applicable):</b>	+		<b>ADD Annual Add-on Rate (if applicable):</b>	+			
<b>Rate Subtotal:</b>	=		<b>Rate Subtotal:</b>	=			
<b>ADD 10% if taking a \$0 Deductible:</b>	+		<b>ADD 10% if taking a \$0 Deductible:</b>	+			
<b>Subtotal:</b>	=		<b>Subtotal:</b>	=			
<b>ADD 15% if you have smoked cigarettes in the 3 years prior to the date of this application:</b>	+		<b>ADD 15% if you have smoked cigarettes in the 3 years prior to the date of this application:</b>	+			
<b>SUBTRACT</b> Federal Superannuate Credit (if applicable):	-		<b>SUBTRACT</b> Federal Superannuate Credit (if applicable):	-			
<b>ADD \$39 for MedipacPLUS (if applicable):</b>	+		<b>ADD \$39 for MedipacPLUS (if applicable):</b>	+			
<b>Total Premium for Applicant 1:</b>	=		<b>Total Premium for Applicant 2:</b>	=			
<b>Total Premium (Applicant 1 + Applicant 2):</b>							





# INSTRUCTION CARD

This instruction card has been designed for you to simplify the application process. Please **read this card fully** before you begin. If you have any questions, please call Medipac for further assistance at **1-888-MEDIPAC** (1-888-633-4722).

## Before you begin:

- We want you to be confident in our policy and protection. Please read the policy carefully, including the Pre-existing Condition and Exclusion Clauses.
- If you're unclear about any of your medical conditions or medications, speak to your doctor.
- If you're not eligible for this plan, call us for information on other Medipac Travel Medical Insurance Plans.

**NOTE:** Trip durations in excess of 183 days are available for Ontario and Newfoundland only.

## Completing the Application (important things to remember):

- The application must be filled out in full and in **pen**.
- All of the medical questions in section A, C and D must be completed.
- An application cannot be processed without specific departure and return dates.
- If you are taking multiple trips, please provide details on a separate sheet of paper. Be sure to include departure date, return date and trip length for each trip.
- Your application must be signed and dated. Please ensure that you have read and understand the Declaration/Authorization section before signing.

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

## Helpful reminders for once your policy has been issued:

- Make sure you have your policy number before you leave for your trip.
- If your health changes prior to your Effective Date of Insurance, call our office immediately to see how your coverage may be affected.
- In a medical emergency, you **must** call Medipac Assist prior to seeking any medical attention.
- Plans change prior to your effective date? Call Medipac to have your dates of travel changed.
- Already on vacation and want to stay longer? Call Medipac **prior** to your scheduled return date to extend your policy.
- Coming home a minimum of 10 days early? You may be eligible for a partial refund for the unused portion of your policy.



# CHECKLIST



## Before you submit your application, ensure that:

- All medical questions have been answered.
- You have indicated your departure and return dates, trip length and deductible.
- Your cheque or credit card payment is included.
- Each applicant has signed and dated Section H with the date the application was actually signed.
- Any changes you made to the application have been initialed by the individual applying for insurance.