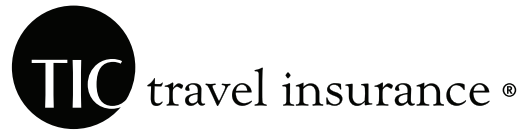


APPLICATION



EMERGENCY HOSPITAL & MEDICAL INSURANCE FOR CANADIANS

PLAN CODE: NOROT

The policy contains a 180-day pre-existing condition clause. If You require coverage for a pre-existing condition, please complete this medical questionnaire and submit the information to TIC Travel Insurance Coordinators Ltd. for consideration.

SECTION 1 APPLICANT INFORMATION, DECLARATION AND AUTHORIZATION

First Name:	Last Name:	
Birth Date: <input type="text"/> M M / <input type="text"/> D D / <input type="text"/> Y Y Y Y	Age: Sex: <input type="text"/> M / <input type="text"/> F	Govt. Health Insurance # (with version code if any):
Mailing Address:		
City/Prov.:		Postal Code:
Telephone Number: ()		E-mail Address:
Do you have other insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		If 'Yes' please indicate:
Have You ever required or received medical treatment or investigation or taken prescription medication for or had a pre-existing condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If you answered 'No' to the question above: complete sections 1 and 2 then mail or fax application to 416-340-0695 or 1-800-533-2350 If you answered 'Yes' to the question above: complete sections 1 and 3 then mail or fax application to 416-340-0790 or 1-866-256-2377		

IMPORTANT – You must sign and date below or Your application will be returned to You!
Any corrections made to the questionnaire must be initialed by You.

I hereby declare that the information provided is truthful, complete and accurate. I understand that this application constitutes part of the contract provided through TIC. I acknowledge that any misrepresentation and non-disclosure of my medical status will result in non-payment of my claim and render my coverage null and void resulting in the refund of my premium. If my health status or medication changes between the date this application is completed and any Departure Date or Top-Up/Extension Effective Date, I must immediately notify TIC of those changes otherwise my coverage will be null and void. I authorize any organization or person having any records or knowledge of my health to give any and all information regarding my health, medical history and treatment to TIC or its authorized representatives. I also understand that any medical information disclosed to TIC prior to the date of completing this application will not form part of the contract unless it is also disclosed in this application. I understand that TIC will collect, use, and/or disclose my personal information to provide me with the requested insurance services, for any other use authorized by me, and/or as required by law. I acknowledge that this coverage is subject to exclusions, terms, conditions and limitations that may limit or exclude an amount payable. A reproduction of this Authorization & Declaration shall be as valid as the original. I understand and agree that refusal or withdrawal of this authorization will result in denial of my application.

Application Date: M M / D D / Y Y Y Y

Applicant Name (print)

Applicant Signature

Broker name (print)

Broker Signature

Broker Number:

SECTION 2 CALCULATION AND PAYMENT OF PREMIUM

Emergency Hospital & Medical Insurance

Departure Date: M M / D D / Y Y Y Y

Effective Date: M M / D D / Y Y Y Y

Return Date: M M / D D / Y Y Y Y

Please name Your beneficiary:

First Name:

Last Name:

Premium Calculation

_____ x \$1.00 = _____
Total Days (including Effective and Return Dates) \$20 minimum premium

Visa MC Amex Diners Cheque Money Order (Please make cheques and money orders payable to TIC Travel Insurance Coordinators Ltd.)

Applicant's Name: _____

Please note: Coverage may be rated or declined. If space is insufficient for any question, print the answer on additional paper, sign and date it and attach it to this form.

SECTION 3 SIMPLIFIED MEDICAL QUESTIONNAIRE

Have You ever received Treatment for, consulted with a physician for, been hospitalized for, taken prescription medication for, or been diagnosed with any of the following:

Condition		Provide name and details of condition
Heart condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cerebrovascular/Neurological	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Respiratory conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Muscle, bone, joint disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Epilepsy/Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any conditions not listed above	<input type="checkbox"/> Yes <input type="checkbox"/> No	

If you answered yes to any of these please provide additional information:

Medical Condition	Date Diagnosed	Current Status
	MM/DD/YYYY	
	MM/DD/YYYY	
	MM/DD/YYYY	

Have you ever been hospitalized or had any surgery? Yes No If yes, please provide details below:

Medical Condition	Surgery/Treatment	Date of Hospitalization/Surgery
		MM/DD/YYYY
		MM/DD/YYYY
		MM/DD/YYYY
		MM/DD/YYYY
		MM/DD/YYYY

Are you currently taking any medication? Yes No If yes, please provide details below:

Medical Condition	Name of Medication	Daily Dosage	Original Date Prescribed	Last Date Dosage was changed	
			MM/DD/YYYY	MM/DD/YYYY	<input type="checkbox"/> INCREASE <input type="checkbox"/> DECREASE
			MM/DD/YYYY	MM/DD/YYYY	<input type="checkbox"/> INCREASE <input type="checkbox"/> DECREASE
			MM/DD/YYYY	MM/DD/YYYY	<input type="checkbox"/> INCREASE <input type="checkbox"/> DECREASE
			MM/DD/YYYY	MM/DD/YYYY	<input type="checkbox"/> INCREASE <input type="checkbox"/> DECREASE
			MM/DD/YYYY	MM/DD/YYYY	<input type="checkbox"/> INCREASE <input type="checkbox"/> DECREASE

Please provide Your Physician Information

Name of Your Physician	Date of Your last visit: MM/DD/YYYY
Physician's Telephone Number	Reason and results of last visit

Definitions

Pre-existing Condition means a sickness, injury or medical condition; which exhibited symptoms or for which treatment has been received or taken, and/or which existed, prior to any departure date and the effective date of Your policy, whether or not the condition had been diagnosed by a physician.
Treatment means a medical, therapeutic or diagnostic procedure prescribed, performed or recommended by a physician, including but not limited to pre-prescribed medication, investigative testing and surgery.

IMPORTANT – You must answer all questions completely. Please provide as much detail as possible to avoid delays in processing Your application.