TD Insurance
Meloche Monnex

Application

for trips over $12,000
to a maximum of $25,000

Non-Medical Travel Insurance

Applicants of all ages
Effective September 28, 2016

Call 1-877-593-8023, one of our representatives will be happy to assist you.
Our office hours are 8 a.m. to 8 p.m. from Monday to Friday and 9 a.m. to 5 p.m. on Saturday ET.
Once completed, please send your application and your cheque payable to RSA:

c/o RSA
1910 King Ouest, Suite 200, Sherbrooke QC J1J 2E2

For Representative Use Only	
Policy Number:	Date Issued (D/M/Y):

SECTION 1 - INSTRUCTIONS

1. You must complete Section 2 in full. This application must be completed at the time you purchase your trip or prior to any cancellation penalties being applicable for the trip. **ONLY YOU can complete and sign the Medical Questionnaire, not your spouse or representative. For any YES answers, you must provide details in K - Comments.**
2. Please return the completed application to your representative.
   Important: Please include a copy of your itinerary and the tour operator/cruise line's penalty structure with this Application, for reference.
3. Once the Application has been reviewed by the Insurer, a decision will be provided in Section 3 and returned to your representative for your notification.
4. Should you decide to purchase, please attach payment and complete Section 4 and return to your representative. **A quote is valid for 7 days from the date the decision is made by the Insurer.**

SECTION 2 – TO BE COMPLETED BY THE APPLICANT

A - Personal Information

Applicant _____ First Name _____ Last Name Date of Birth (D/M/Y) _____/_____/_____ ☐ Male ☐ Female

Home Address _____ Street _____ City _____ Province

_____ Postal Code _____ Telephone _____ E-mail

B - Trip Information

_____ Departure Date (D/M/Y) _____ Return Date (D/M/Y) _____ Number of Travel Days

_____ Departing From _____ Trip Destination(s)

Travel Arrangements include: ☐ Air ☐ Cruise ☐ Land ☐ Rail ☐ Other

Supplier of Travel Arrangements: _____

$ _____ CAD _____ Total Cost of Travel Arrangements _____ Applicable penalties (after departure) _____ Applicable penalties (prior to departure)

Please indicate the nature of the trip including any high risk activities planned during the trip:

_____

If applying for non-medical travel insurance only, please provide the reason why emergency medical coverage is not required. Please include existing insurance carrier (i.e. employer group plan, credit card, other insurance).

_____ Existing Insurance Carrier _____ Policy Number

Important: When submitting this application, please attach a copy of your itinerary and the tour operator or cruise line's penalty structure.

C - Definitions

Throughout the Medical Questionnaire, defined words are written in italics. Please refer to them as they are important definitions.

1. **Terminal illness:** means that you have a medical condition that is cause for a physician to estimate that you have less than 6 months to live or for which palliative care has been received.
2. **Metastatic cancer:** means a cancer that has spread from its original site to one or more other area(s) of the body.

I understand that in the event of a claim, the answers I provide herein will be reviewed for accuracy by the Insurer. If they are inaccurate in any way, my claim will be denied.

D - Are you eligible?

This insurance is only available if you are a Canadian resident covered by the Government Health Insurance Plan of your Canadian province or territory of residence for the entire duration of your trip.

	Eligible	Not Eligible
1. Coverage is NOT AVAILABLE to any individual who: • is travelling against the advice of a physician; • has been diagnosed with a *terminal illness* or *metastatic cancer*; • has a kidney disease requiring dialysis; or • has been prescribed or used home oxygen in the 12 months prior to their application date; **Please confirm your eligibility to apply for this insurance.**	☐	☐

If you are Eligible, please continue to the next section.

Important: For any YES answers in E to J, you must provide details in K – Comments.

E – Heart Condition

In the past **10 years**:	YES	NO
1. Have you been diagnosed with a cardiac condition?	☐	☐
2. Have you suffered from angina (chest pain)?	☐	☐
3. Have you been diagnosed with heart failure (for example, shortness of breath, fatigue, ankle/leg swelling or edema)?	☐	☐
4. Have you used nitroglycerine (spray or pill) regularly? **If YES, please indicate how often:** ☐ **Daily** ☐ **Weekly** ☐ **Monthly**	☐	☐
5. Have you had a heart attack? **If YES, please indicate when** (d/m/y):	☐	☐
6. Have you had a coronary angioplasty? **If YES, please indicate when** (d/m/y):	☐	☐
7. Have you had heart bypass surgery? **If YES, please indicate when** (d/m/y):	☐	☐
8. Have you been prescribed or taken Lasix, Furosemide or other generics (including for high blood pressure)? **If YES, please indicate dosage _____ mg per day**	☐	☐
9. Have you been diagnosed with an atrial fibrillation?	☐	☐
10. Have you been prescribed or taken a blood thinner for a heart condition?	☐	☐
11. Have you been hospitalized for any other heart condition (excluding chest pain/angina, heart attack, angioplasty, heart bypass surgery, heart failure, atrial fibrillation)? **If YES, please describe the diagnosis and indicate when** (d/m/y):	☐	☐

F – Lung Condition

In the past **12 months**:	YES	NO
1. Have you been diagnosed with a lung condition (including lung cancer or pneumonia)? **If YES, please describe the diagnosis and indicate when** (d/m/y):	☐	☐
2. Do you use a puffer/inhaler regularly? **If YES, please indicate how often:** ☐ **Daily** ☐ **Weekly** ☐ **Monthly**	☐	☐
3. Have you been prescribed or taken Prednisone, Deltasone or other generic for a lung condition? **If YES, please indicate when** (d/m/y):	☐	☐
4. Have you been hospitalized for a lung condition? **If YES, please describe the diagnosis and indicate when** (d/m/y):	☐	☐

G – Stroke/Mini-Stroke/PVD

In the past **12 months**:	YES	NO
1. Have you had a stroke (CVA) or mini-stroke (TIA)?	☐	☐
2. Have you been diagnosed with peripheral vascular disease (PVD), Carotid Artery Stenosis or any narrowed or blocked artery, excluding coronary artery disease? **If YES, please indicate when** (d/m/y):	☐	☐
3. Have you been prescribed or taken a blood thinner for a stroke (CVA), mini stoke (TIA), peripheral vascular disease (PVD) or Carotid Artery Stenosis?	☐	☐
4. Have you been hospitalized for a stroke (CVA), mini-stroke (TIA), peripheral vascular disease (PVD) or Carotid Artery Stenosis? **If YES, please indicate when** (d/m/y):	☐	☐

H – Diabetes

In the past **12 months**:	YES	NO
1. Have you been diagnosed with diabetes? **If YES, indicate how your diabetes is controlled (select any that apply):** ☐ **Diet** ☐ **Oral Medication** ☐ **Insulin**	☐	☐
2. Do you check your blood sugar? **If YES, please indicate how often**: ☐ **Daily** ☐ **Monthly**	☐	☐
3. Have you been hospitalized for diabetes? **If YES, please indicate when** (d/m/y):	☐	☐

I – High Blood Pressure

In the past **12 months**:	YES	NO
1. Have you been diagnosed with high blood pressure?	☐	☐
2. Have you been prescribed or taken medication for high blood pressure?	☐	☐
3. Have you been hospitalized for high blood pressure? **If YES, please indicate when** (d/m/y):	☐	☐

J – Other

	YES	NO
1. Have you ever had an organ transplant (excluding corneal transplant)? **If YES, please indicate the type of transplant and the date** (m/d/y):	☐	☐
2. Have you been prescribed or are you currently taking medication for any medical condition NOT listed in PARTS E to I? **If YES, please indicate for which medical condition**:	☐	☐

K – Comments

Provide details to Yes answers (if more space is needed, attach an additional piece of paper, sign and date it).

Question Number	Illness/Impairment	Date of Diagnosis and all Medication Names (if applicable)

IMPORTANT NOTICE

Important Notice About Your Personal Information: By submitting this application you agree that Royal & Sun Alliance Insurance Company of Canada ("we", "us") may collect, use and disclose your Personal Information (including to and from your broker, our affiliates and service providers and organizations that may have referred you to us, and professional associations of which you may be a member) for purposes of quoting a premium, policy administration, improving customer experience, administering referral arrangements, and for other lawful purposes described in our Protecting Customer Privacy document. For a copy of this document please see www.rsatravelinsurance.com.

L - Agreement, Understanding and Authorization

You must read and understand the importance of each of the following statements and **sign below**.

- **A PRE-EXISTING MEDICAL CONDITION EXCLUSION** may apply to medical conditions and/or symptoms that existed prior to my effective date. I understand that any medical condition I have, including those disclosed in **SECTION 2** will be subject to the exclusions of the policy. I will refer to my policy for details.
- Where I was unsure of my medical history as it relates to the medical questions, I have verified it with my physician. I personally provided the answers on this Medical Questionnaire and I warrant that all information disclosed herein is correct and complete. In the event of a claim, I fully understand that the Insurer will review my prior medical history and these answers and, if any of my answers are incorrect or incomplete, the Insurer will void my policy and my claim will be refused, regardless of whether the incorrect or incomplete answer to any question is related to the cause of my claim or would have rendered me ineligible or resulted solely in a higher applicable premium. I understand that the answers on my Medical Questionnaire are relevant to the risk and constitute the basis of my insurance.
- Medical Authorization in Case of a Claim – I understand that the insurer may investigate my claim. By signing this Medical Questionnaire, I also hereby direct and authorize any physician, health care practitioner, hospital or other medical care facility, pharmacy, the Ministry of Health or any other person who has attended and examined me or who has knowledge or records of me or my health, to furnish to Royal & Sun Alliance Insurance Company of Canada and to its authorized administrator, Global Excel Management Inc., any or all information with respect to my sickness, injury, medical history, consultations, medicines or treatment and copies of all hospital or medical records for the purpose of investigating my claim.
- I understand that some exclusions may apply and affect my coverage. I will read my insurance policy for additional details.

Applicant Signature | Date of Signature (D/M/Y)

SECTION 3 – TO BE COMPLETED BY THE INSURER

A - Decision

☐ Declined - the Applicant is not eligible for coverage ☐ Approved Date (D/M/Y) _____

B – Quote Details

This quote is valid for 7 days from the date a decision is made by the Insurer.

Premuim		Surcharge		Subtotal		Applicable Sales Tax		TOTAL PREMIUM
$	+	$	=	$	+	$	=	$

SECTION 4 – TO BE COMPLETED BY THE APPLICANT

A - Payment

Method of Payment ☐ Visa ☐ MasterCard ☐ AMEX ☐ Cheque made payable to RSA

Credit Card Information

Card Number | Expiry Date (M/Y)

Name of Cardholder | Signature of Cardholder | Date Signed (D/M/Y)

This insurance is underwritten by Royal & Sun Alliance Insurance Company of Canada and distributed in some provinces by RSA Travel Insurance Inc., operating as RSA Travel Insurance Agency in British Columbia.

TD Insurance Meloche Monnex is the Business name of Security National Insurance Company.