



For more information, call 1-800-360-3234 or visit Ingle online at [www.ingletravel.com](http://www.ingletravel.com)

Please send your completed application and your cheque payable to:

**Ingle International & Imagine Financial Ltd.**  
460 Richmond Street West, Suite 100  
Toronto, Ontario M5V 1Y1

**For Broker / Sales Agent Use Only** 11 26 CAL ECA 0810 PHO

Applicant 1 Policy Number:	Applicant 2 Policy Number:	Date Issued (D/M/Y):
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<b>Applicant 1</b>	<div style="display: flex; justify-content: space-between;"> <span>First Name</span> <span>Last Name</span> </div>	Date of Birth (D/M/Y) ____/____/____ <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Applicant 2</b>	<div style="display: flex; justify-content: space-between;"> <span>First Name</span> <span>Last Name</span> </div>	Date of Birth (D/M/Y) ____/____/____ <input type="checkbox"/> Male <input type="checkbox"/> Female

Refer to the Rate Sheet for premiums.

Medical Coverage	Applicant 1	Applicant 2
<b>A. Enter your SINGLE TRIP DAILY RATE</b> Applicable if you are purchasing Single Trip Daily coverage or Topping-up a Medi-Select Advantage Annual Plan. Use the total trip duration to determine your daily rate.	\$ A	\$ A
<b>B. SINGLE TRIP DAILY Premium</b> Multiply the number of days required by the SINGLE TRIP DAILY RATE. <span style="border: 1px solid black; padding: 2px;">DAYS REQUIRED</span> x BOX A	\$ B	\$ B
<b>C. Smoker Surcharge</b> If you answered Yes to Question 15, add 20% to BOX B. If you answered No to Question 15, carry BOX B forward.	\$ C	\$ C
<b>D. Deductible Options</b> Applicant 1 <input type="checkbox"/> \$0 (+10%) <input type="checkbox"/> \$250 US (0%) <input type="checkbox"/> \$500 US (-5%) <input type="checkbox"/> \$1,000 US (-10%) <input type="checkbox"/> \$5,000 US (-30%) <input type="checkbox"/> \$10,000 US (-45%) Applicant 2 <input type="checkbox"/> \$0 (+10%) <input type="checkbox"/> \$250 US (0%) <input type="checkbox"/> \$500 US (-5%) <input type="checkbox"/> \$1,000 US (-10%) <input type="checkbox"/> \$5,000 US (-30%) <input type="checkbox"/> \$10,000 US (-45%) Calculate and add or subtract the appropriate % to BOX C based on the selected deductible.	\$ D	\$ D
<b>E. OPTIONAL OUT-OF-NETWORK COVERAGE Premium</b> <span style="border: 1px solid black; padding: 2px;">DAYS REQUIRED</span> x \$5 Multiply the number of days required by \$5.	\$ E	\$ E
<b>F. Medical Coverage SUBTOTAL</b> BOX D + BOX E.	\$ SUBTOTAL F	\$ SUBTOTAL F

<b>Applicable Discount</b> <b>G. Companion Discount</b> If you are purchasing this Policy as a companion, a 5% savings applies (BOX F x 0.95). If not, carry BOX F forward.	\$ G	\$ G
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<b>H. TOTAL Premium Due</b> There is a minimum premium of \$25 per applicant. (Not applicable to the Optional Out-of-Network Coverage)	\$ TOTAL H	\$ TOTAL H
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Please attach this page to your Application Form and complete the "Total Premium for all Applicants" and "Method of Payment" sections at the bottom of Page 4.

