Viacare™ Southeast Florida

INGLE™ INTERNATIONAL

etfs®

Application

Age 55 or over

Effective August 2010

For more information **Call 1-800-360-3234** or visit Ingle online at **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 APM ECA 0810 SEF
Applicant 1 Policy Number:	**Applicant 2** Policy Number:	Date Issued (D/M/Y):

The Viacare Southeast Florida policy contains different levels of benefit coverage based upon whether care is provided by In-Network providers or Out-of-Network providers.

This Application must be completed prior to the effective date. ONLY YOU can complete and sign the Medical Questionnaire, not your spouse, broker or sales agent. Should you need to make a correction to your answers pertaining to the medical questions in this Application, please call your broker or sales agent for instructions.

A .:Personal Information

Your personal information is collected for the purpose of providing you with insurance services, claims analysis and payments. For a copy of the **etfs** Privacy Policy, please see www.etfsinc.com. For Privacy Information, please see www.rsagroup.ca

Applicant 1

First Name | Last Name | Date of Birth (D/M/Y) ______/______/______ ☐ Male ☐ Female

Applicant 2

First Name | Last Name | Date of Birth (D/M/Y) ______/______/______ ☐ Male ☐ Female

Home Address

Street | City | Province

Postal Code | Telephone | E-mail

Destination Address

Street | City | Province / State / Country

Postal / Zip Code | Telephone | E-mail (if different from home e-mail)

Emergency Contact

First Name | Last Name | Telephone

B .: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.
3. **Treated**: means that you have been hospitalized, have been prescribed medication (including prescribed as needed), have taken or are currently taking medication or have undergone a medical or surgical procedure. Note that Aspirin/Entrophen is not considered treatment.
4. **Stable**: means any medical condition (other than a *minor ailment*) for which all the following statements are true:
   a. There has been no new diagnosis, treatment or prescribed medication.
   b. There has been no change in treatment or change in medication, including the amount of medication to be taken, how often it is taken, the type of medication or change in treatment frequency or type.
   Exceptions: the routine adjustment of Coumadin, Warfarin, insulin or oral medication to control diabetes (as long as they are not newly prescribed or stopped) and a change from a brand name medication to a generic brand medication (provided that the dosage is not modified);
   c. There have been no new symptoms, more frequent symptoms or more severe symptoms.
   d. There have been no test results showing deterioration.
   e. There has been no hospitalization or referral to a specialist (made or recommended) and you are not awaiting the results of further investigations for that medical condition.
5. **Minor ailment**: means any sickness or injury which does not require: the use of medication for a period of greater than 15 days; more than one follow up visit to a physician, hospitalization, surgical intervention or referral to a specialist; and which ends at least 30 consecutive days prior to the departure date of each trip. However, a chronic condition or complications of a chronic condition are not considered a minor ailment.
6. **Regular check-up**: means any standard or customary medical examination unrelated to any specific medical condition and which is carried out for the purpose of screening, health monitoring or preventive care and may include routine medical tests and investigations.

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 innacurate in any way, my claim will be denied.

C .:Are you eligible?

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

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;
- has been prescribed or used **home oxygen** in the 12 months prior to their application date;
- has been diagnosed with **AIDS** (Acquired Immune Deficiency Syndrome); or
- has been diagnosed with **HIV** (Human Immunodeficiency Virus).

Please confirm your eligibility to apply for this insurance.

Applicant 1	Applicant 2
☐ Eligible	☐ Eligible
☐ Not Eligible	☐ Not Eligible

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

D .:Do you require customized Medical Underwriting?

Question	Applicant 1	Applicant 2
2. Have you had **Heart bypass surgery** more than 10 years prior to your application date (use the date of the most recent bypass)?	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you had **Heart angioplasty** (including stent placement) more than 10 years prior to your application date (use the date of the most recent angioplasty)?	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you ever had a **Bone marrow transplant** or an **Organ transplant** (excluding corneal transplant)?	☐ Yes ☐ No	☐ Yes ☐ No
5. Do you have an **Aneurysm** of 3.5 cm or more which remains surgically unrepaired?	☐ Yes ☐ No	☐ Yes ☐ No
6. During the 5 years prior to your application, have you been diagnosed with or *treated* for **Congestive heart failure** or are you currently taking **Lasix**, **Furosemide** or a **water pill** (excluding a water pill taken for high blood pressure only)?	☐ Yes ☐ No	☐ Yes ☐ No
7. During the 12 months prior to your application, have you had:		
a. Any **Heart condition** for which you were hospitalized or required a change in medication? (Refer to part b. of the *stable* definition.)	☐ Yes ☐ No	☐ Yes ☐ No
b. A **Lung condition** (including pneumonia) which required hospitalization or treatment with **Prednisone** (**Deltasone** or other generics)?	☐ Yes ☐ No	☐ Yes ☐ No
8. During the 12 months prior to your application, have you been diagnosed with or *treated* for 3 or more of the following conditions?	☐ Yes ☐ No	☐ Yes ☐ No

- **Diabetes** (*treated* with oral medication or insulin)
- **Peripheral vascular disease** (PVD: narrowing or blockage of any blood vessel)
- **Lung condition** (including any prescription for puffers/inhalers) **excluding lung cancer** or a *minor ailment*
- **Heart condition** (including stent placement, pacemaker and/or defibrillator)
- **Stroke** or **Mini-stroke** (CVA/TIA)
- **High blood pressure**

If you have answered YES to ANY question in Section D above, please contact your broker or sales agent. Otherwise, please continue.

E .:Which plan do you qualify for?

Question	Applicant 1	Applicant 2
9. During the 2 years prior to your application, have you been diagnosed with or *treated* for any of the following:	☐ Yes 5 pts ☐ No	☐ Yes 5 pts ☐ No

- **Chronic bowel disease** (such as but not limited to Crohn's disease or Ulcerative colitis)?
- **Gallbladder disease** (including stones)? Not applicable if your gallbladder has been removed.
- **Gastrointestinal bleeding**, **Bowel obstruction** or have had **Bowel surgery**?
- **Kidney disease** (including stones), **Liver disease** or **Pancreatitis**?

Question	Applicant 1	Applicant 2
10. During the 10 years prior to your application, have you been diagnosed with or *treated* for a **Heart condition** (including stent placement, pacemaker and/or defibrillator)?	☐ Yes 5 pts ☐ No	☐ Yes 5 pts ☐ No

Section E - Continued on next page

	Applicant 1		Applicant 2	
11. During the 5 years prior to your application, have you been diagnosed with or *treated* for:				
a. **Diabetes** (*treated* with oral medication or insulin or controlled by diet) or **Glucose intolerance** (pre-diabetes)?	☐ Yes 5 pts	☐ No	☐ Yes 5 pts	☐ No
b. **Stroke** or **Mini-stroke** (CVA/TIA)?	☐ Yes 5 pts	☐ No	☐ Yes 5 pts	☐ No
c. **Peripheral vascular disease** (PVD: narrowing or blockage of any blood vessel)?	☐ Yes 5 pts	☐ No	☐ Yes 5 pts	☐ No
d. **Lung condition** (such as any prescription for puffers/inhalers) **excluding lung cancer** or a *minor ailment*?	☐ Yes 5 pts	☐ No	☐ Yes 5 pts	☐ No
e. **Dementia** or **Alzheimer's disease**?	☐ Yes 5 pts	☐ No	☐ Yes 5 pts	☐ No
f. **Cancer** (excluding basal or squamous cell skin cancer or breast cancer *treated* only with **Tamoxifen**, **Femara** or **Arimidex**)?	☐ Yes 5 pts	☐ No	☐ Yes 5 pts	☐ No
12. Have you ever been diagnosed with or *treated* for any of the following conditions: • **Heart condition** (including stent, pacemaker and/or defibrillator)? • **Stroke** or **Mini-stroke** (CVA/TIA)?	☐ Yes 1 pt	☐ No	☐ Yes 1 pt	☐ No
13. Has it been more than 18 months since your last ***regular check-up*** with a physician?	☐ Yes 1 pt	☐ No	☐ Yes 1 pt	☐ No
14. During the 12 months prior to your application, have you been diagnosed with or *treated* for:				
a. **High blood pressure**?	☐ Yes 1 pt	☐ No	☐ Yes 1 pt	☐ No
b. **High cholesterol**?	☐ Yes 1 pt	☐ No	☐ Yes 1 pt	☐ No
15. During the 5 years prior to your application, have you smoked cigarettes?	☐ Yes 0 pts	☐ No	☐ Yes 0 pts	☐ No
Total Points (Yes answers for Questions 9 to 14)				

F .:Qualification Table

PLEASE INDICATE THE COVERAGE YOU QUALIFY FOR and read the Pre-Existing Medical Condition Exclusions.

Total Points	You Qualify for	Pre-Existing Period	Applicant 1	Applicant 2
0	Supreme	90 days	☐	☐
1	Elite	90 days	☐	☐
2 to 4	Preferred	90 days	☐	☐
5 to 9	Advantage	365 days	☐	☐
10 or more	Standard	365 days	☐	☐

Pre-Existing Medical Condition Exclusions

This insurance does not cover losses or expenses caused directly or indirectly, in whole or in part, by:

1. Any sickness, injury or medical condition (other than a *minor ailment*) that was not *stable* at any time during the applicable Pre-Existing Period prior to each departure date.
2. Your heart condition, if **any** heart condition was not *stable* at any time during the applicable Pre-Existing Period prior to each departure date.
3. Your lung condition, if:
   a. **any** lung condition was not *stable*; or
   b. you have been *treated* with home oxygen or taken oral steroids (e.g., prednisone) for **any** lung condition, at any time during the applicable Pre-Existing Period prior to each departure date.

G .: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 trip. I understand that any medical condition I have, including those disclosed in **SECTION E**, will be subject to the Pre-Existing Medical Condition Exclusions as stated above. I will refer to my policy and to the above for the full Pre-Existing Medical Condition Exclusion clause.
- 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 question is related to the cause of my claim. I understand that the answers on my Medical Questionnaire are relevant to the risk and constitute the basis of my insurance.
- I understand the necessity of calling Global Excel Management Inc. and obtaining prior approval before seeking medical attention in case of a claim or medical emergency. The toll free telephone number can be found on my wallet card and in my insurance policy.
- Medical Authorization in Case of a Claim – I understand that Royal & Sun Alliance Insurance Company of Canada and Global Excel Management Inc. 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 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 1 Signature Date of Signature (D/M/Y)

Applicant 2 Signature Date of Signature (D/M/Y)

Important Notice

If your health changes or does not remain *stable* between the date you complete and submit this Medical Questionnaire and your departure date, **you must review the medical questions with your broker or sales agent** to re-assess your eligibility. If you are no longer eligible for the insurance plan you purchased and you fail to contact your broker or sales agent, your claim will be denied, the Insurer will void your policy, and the premium you paid will be refunded. This means no benefits will be covered and you will be responsible for all expenses relating to your sickness or injury, including repatriation costs (see Pre-Existing Medical Condition Exclusions).

H .:Trip Information

Check the applicable Plan and Qualification you are applying for.

Applicant 1

Plan

☐ **Single Trip Daily or Top-Up**

Departure Date (D/M/Y): ____/____/____

Effective Date (D/M/Y): ____/____/____ Expiry Date (D/M/Y): ____/____/____

☐ **Optional Out-of-Network Coverage**

Effective Date (D/M/Y): ____/____/____ Expiry Date (D/M/Y): ____/____/____

If you are purchasing a Top-Up to an existing coverage, the Effective Date will be the day after your existing coverage terminates.

Top-Up

Policy number of Medi-Select Advantage Plan: ______________________________

Number of Pre-insured days: ______________

Qualification

☐ **Supreme** ☐ **Elite** ☐ **Preferred** ☐ **Advantage** ☐ **Standard**

Deductible Options*

☐ $0 (+10%) ☐ **$250 US (0%)** ☐ $500 US (-5%)
☐ $1,000 US (-10%) ☐ $5,000 US (-30%) ☐ $10,000 US (-45%)

* The selected deductible option applies for both the Single Trip Daily Plan and the Optional Out-of-Network Coverage.

Smoker†

During the 5 years prior to your application, have you smoked cigarettes? ☐ Yes ☐ No

† The Smoker surcharge (+20%) applies only to the Single Trip Daily premium.

Applicant 2

Plan

☐ **Single Trip Daily or Top-Up**

Departure Date (D/M/Y): ____/____/____

Effective Date (D/M/Y): ____/____/____ Expiry Date (D/M/Y): ____/____/____

☐ **Optional Out-of-Network Coverage**

Effective Date (D/M/Y): ____/____/____ Expiry Date (D/M/Y): ____/____/____

If you are purchasing a Top-Up to an existing coverage, the Effective Date will be the day after your existing coverage terminates.

Top-Up

Policy number of Medi-Select Advantage Plan: ______________________________

Number of Pre-insured days: ______________

Qualification

☐ **Supreme** ☐ **Elite** ☐ **Preferred** ☐ **Advantage** ☐ **Standard**

Deductible Options*

☐ $0 (+10%) ☐ **$250 US (0%)** ☐ $500 US (-5%)
☐ $1,000 US (-10%) ☐ $5,000 US (-30%) ☐ $10,000 US (-45%)

* The selected deductible option applies for both the Single Trip Daily Plan and the Optional Out-of-Network Coverage.

Smoker†

During the 5 years prior to your application, have you smoked cigarettes? ☐ Yes ☐ No

† The Smoker surcharge (+20%) applies only to the Single Trip Daily premium.

I .:Premium and Payment

For manual applications, please complete the Premium Calculation – Plans without Medical Questionaire page to determine each Applicant's total premium. If you require assistance, please contact us.

Total Premium $ Applicant 1 + $ Applicant 2 = $ TOTAL

Method of Payment ☐ Visa ☐ MasterCard ☐ AMEX ☐ Cheque made payable to the broker or sales agent indicated on the front of this application.

Card Number	Expiry Date (M/Y)	Signature of Cardholder	Date Signed (D/M/Y)

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