Destination TRAVEL HEALTH PLANS

Application for Travel Medical Insurance

Effective as of January 15, 2019

Questions? *Contact your Broker or call us at 1-855-337-3532*

PART 1 ELIGIBILITY REQUIREMENTS - Words shown in italics are defined in Part 8 and 9 on page 4 of this application

You must be over the age of 14 days and under age 90 on the date of your application, a Canadian resident and be covered by the government health insurance plan (GHIP) of your Canadian province/territory of residence for the entire duration of your trip. You must meet all the eligibility requirements as stated below in # 1, 2, 3 and 4. If you are unsure of your eligibility based on your medical history, please consult with your physician.

If you are under age 55 or over age 89, call your broker or Destination: Travel Group Inc. at the above number to inquire about our Destination: Travel Leisure Plan or our over age 89 products.

COVERAGE IS NOT AVAILABLE TO ANY INDIVIDUAL WHO:

1.
- **a)** has been diagnosed with a *terminal illness;*
- **b)** has been diagnosed with acquired immune deficiency syndrome (AIDS) or Human Immune Deficiency Virus (HIV);
- **c)** received *treatment* for pancreatic cancer, liver cancer or any type of cancer that has metastasized;
- **d)** had an organ transplant (heart, lung, liver, kidney) or a bone marrow or stem cell transplant;
- **e)** has been diagnosed with or received *treatment* for congestive heart failure or cardiomyopathy in the last 24 months;
- **f)** has had a *lung condition* for which the use of home oxygen has been prescribed in the last 24 months;
- **g)** has been diagnosed with or received *treatment* for Stage 4 or Stage 5 chronic kidney disease or any kidney condition requiring dialysis, or;
- **h)** requires *assistance with activities of daily living.*

IN ADDITION TO QUESTION 1 ABOVE, TO BE ELIGIBLE FOR COVERAGE:

2. You must not have had, prior to your application date, your most recent heart surgery (if any) more than **12 years ago.** **Heart surgery** includes coronary bypass, coronary angioplasty, valve surgery (repair or replacement), valvuloplasty, implanted pacemaker or implanted defibrillator (excluding battery change).

3. In the 12 months prior to your application date, you must not have:

a) been hospitalized for 24 hours or more for **any** of the following medical conditions:

- *Artery* or *Vein disorder*
- *Heart condition*
- *Lung condition*
- Diabetes (excluding diet controlled)
- Stroke (CVA), Transient Ischemic attack (TIA)
- Liver or Pancreas disorder
- *Bowel/stomach disorder*
- Cancer (excluding basal or squamous cell skin cancer and breast cancer *treated* only with hormone therapy)

b) been diagnosed or *treated* for **3 or more** of the medical conditions listed in Question 3 a) above;

c) been prescribed a total of **6 or more** separate and distinct prescription medications (excluding aspirin and prescriptions for *minor conditions*) for all of the medical conditions combined as listed in Question 3 a) above;

4. You must not have had, on your application date, a diagnosed aneurysm of **4 centimeters or more** in either length or diameter, that has not been surgically repaired.

If you do not meet all the above eligibility requirements, you are not eligible to purchase this insurance; other coverage options may be available. Please consult with your insurance broker or agent or contact us at 1-855-337-3532.

IF YOU ARE ELIGIBLE, PLEASE COMPLETE THE BALANCE OF THIS APPLICATION.

IMPORTANT: If your health status changes prior to the effective date indicated on your Confirmation of Coverage which makes you no longer eligible for this policy, you must notify Destination: Travel Group Inc. immediately and upon submission of proof of ineligibility, will receive a full refund. For Annual Multi-Trip plans, if your health changes after the effective date indicated on your Confirmation of Coverage, your eligibility will not be affected but coverage for that medical condition will be subject to your pre-existing medical conditions exclusion.

I have read the above eligibility requirements. I understand them, and declare that I am eligible. I acknowledge that any policy and coverage provided to me on the basis of the answers given will be deemed null and void if any answer is not correct.

SIGN HERE ✕ Signature Required

Applicant 1 Signature

SIGN HERE ✕ Signature Required

Applicant 2 Signature

PART 2 APPLICANT INFORMATION

Applicant 1

Last Name

First Name

Date of Birth DD / MM / YY | Age at Application

Applicant 2

Last Name

First Name

Date of Birth DD / MM / YY | Age at Application

Address | Suite

City | Prov. | Postal Code | Phone ( )

Email Address (if any)

Emergency Contact Name | Phone ( )

Underwritten by: CUMIS General Insurance Company, a member of The Co-operators group of companies.
Claims Administration and Assistance Services provided by: Allianz Global Assistance **Managed and distributed by:** The Destination: Travel Group Inc.

PART 3 PLAN CLASSIFICATION - Medical Definitions defined on page 4 - Part 8 of application

Please answer "Yes" or "No" to all questions below.
"No" answers equal "0" points

1. During the 24 months prior to your application date, have you been diagnosed with, received *treatment* for, or been prescribed medication (including aspirin) for any of the following medical conditions:	× FIRST NAME OF APPLICANT 1 (PRINT ABOVE) Yes	No	× FIRST NAME OF APPLICANT 2 (PRINT ABOVE) Yes	No
a) *Heart condition*	○ 6 pts	○	○ 6 pts	○
b) *Lung condition* (excluding asthma)	○ 6 pts	○	○ 6 pts	○
c) Diabetes (excluding diet controlled)	○ 6 pts	○	○ 6 pts	○
d) Stroke (CVA) or Transient Ischemic Attack (TIA)	○ 6 pts	○	○ 6 pts	○
e) *Bowel / Stomach disorder* (excluding diverticulitis)	○ 6 pts	○	○ 6 pts	○
f) Cancer (excluding basal or squamous cell skin cancer and breast cancer *treated* only with hormone therapy)	○ 6 pts	○	○ 6 pts	○
g) *Artery or vein disorder*	○ 5 pts	○	○ 5 pts	○
h) Diverticulitis	○ 4 pts	○	○ 4 pts	○
i) *Neurological disorder*	○ 3 pts	○	○ 3 pts	○
j) Pancreas disorder	○ 3 pts	○	○ 3 pts	○
k) Liver disorder	○ 3 pts	○	○ 3 pts	○
l) Kidney disorder	○ 3 pts	○	○ 3 pts	○
m) High Blood Pressure				
i) *treated* at any one time with 3 or more medications	○ 6 pts	○	○ 6 pts	○
ii) *treated* at any one time with 1 or 2 medication(s) only	○ 1 pt	○	○ 1 pt	○
n) Asthma	○ 2 pts	○	○ 2 pts	○
o) Diet controlled diabetes	○ 1 pt	○	○ 1 pt	○
2. Prior to your application date, has it been more than 24 months since you have undergone a medical check-up?	○ 2 pts	○	○ 2 pts	○
	Total Points =		Total Points =	

Total Points	Applicant 1	Applicant 2	Plan Classification	Automatic Stability Period **Definition of *stable/stability* on page 4 - Part 9 of this application
0 to 1 point	○	○	Premier Plan	90 days
2 to 5 points	○	○	Ultra Preferred	180 days (90 days for high blood pressure)
6 to 11 points	○	○	Super Preferred	365 days (90 days for high blood pressure)
12 to 16 points	○	○	Elite Preferred	365 days (90 days for high blood pressure)
17 points +	○	○	Not Eligible	Not Eligible - Please contact your broker or Destination: Travel Group Inc. for more options

PART 4 REDUCED STABILITY PERIOD OPTIONS

You may choose to cover your pre-existing medical condition(s) that does not meet the *stability* period as described above in your plan classification by purchasing a Reduced Stability Period option. If you select this option, coverage is limited to $150,000 CAD applicable only to that medical condition(s) or related condition(s) that does not meet the automatic *stability* period above but does meet the *stability* period stated in your selected option below.

Do you want to purchase the Reduced Stability Period Option? Applicant 1 ○Yes ○No ..... Applicant 2 ○Yes ○No

Plan Classification (as per Part 3)	Option 1 Applicant 1	Option 1 Applicant 2	Option 2 Applicant 1	Option 2 Applicant 2
Premier Plan	30 days (20% surcharge) ○	○		
Ultra Preferred	30 days (20% surcharge) ○	○		
Super Preferred	90 days (30% surcharge) ○	○	180 days (20% surcharge) ○	○
Elite Preferred	90 days (30% surcharge) ○	○	180 days (20% surcharge) ○	○

I have read and answered the questions under Part 3 – Plan Classification. **I UNDERSTAND THEM, AND I ACKNOWLEDGE THAT ANY POLICY AND COVERAGE PROVIDED TO ME ON THE BASIS OF THE ABOVE PLAN CLASSIFICATION I HAVE SELECTED WILL BE DEEMED NULL AND VOID IF I DO NOT QUALIFY FOR THE PLAN SELECTED.**

I further understand that if I qualify for one of the above plan classifications, I will be covered for any medical condition(s) that has been *stable* at all times during the *stability* period described in your chosen plan classification. The *stability* period applies prior to: (i) each date I depart my province/territory of residence for the Annual/Multi-Trip Plan coverage; and/or (ii) the policy effective date for the Single Trip Plan and/or Top-Up Plan coverage.

SIGN HERE × Signature Required
Applicant 1 Signature

SIGN HERE × Signature Required
Applicant 2 Signature

PART 5 TRAVEL INFORMATION - Please base your rates on the plan classification you selected in Part 3 and Part 4 of Page 2

Applicant 1 Section

SINGLE TRIP COVERAGE (Count both the Departure and Return Dates when determining the # of Travel Days)

Departure Date (Policy Effective Date) DD / MM / YY

Return Date (Policy Expiry Date) DD / MM / YY

Daily Rate _____ X # of Days _____ = $ _____ **A1**

ANNUAL / MULTI-TRIP COVERAGE Covers the first 8, 15, 30 or 60 days of any trip taken during the 365-day period from your policy effective date (age restrictions apply).

◯ 8 Days ◯ 15 Days ◯ 30 Days ◯ 60 Days

Policy Effective Date DD / MM / YY

Annual / Multi-Trip Premium = $ _____ **B1**

TOP UP COVERAGE (Must be purchased **BEFORE** Departure. Extends other coverage or your **Destination: Travel Health Plans** Annual/Multi-Trip

(Please ensure that the top-up policy effective date is the day after your other coverage

Departure Date DD / MM / YY

Top-up Policy Effective Date DD / MM / YY

Return Date (Policy Expiry Date) DD / MM / YY

Top-up Trip Length DD MM YY

# of days of Existing Coverage

Premium for Top-Up Coverage

Daily Rate _____ X # of Days _____ = $ _____ **C1**

Applicant 2 Section

SINGLE TRIP COVERAGE (Count both the Departure and Return Dates when determining the # of Travel Days)

Departure Date (Policy Effective Date) DD / MM / YY

Return Date (Policy Expiry Date) DD / MM / YY

Daily Rate _____ X # of Days _____ = $ _____ **A2**

ANNUAL / MULTI-TRIP COVERAGE Covers the first 8, 15, 30 or 60 days of any trip taken during the 365-day period from your policy effective date (age restrictions apply).

◯ 8 Days ◯ 15 Days ◯ 30 Days ◯ 60 Days

Policy Effective Date DD / MM / YY

Annual / Multi-Trip Premium = $ _____ **B2**

TOP UP COVERAGE (Must be purchased **BEFORE** Departure. Extends other coverage or your **Destination: Travel Health Plans** Annual/Multi-Trip

(Please ensure that the top-up policy effective date is the day after your other coverage

Departure Date DD / MM / YY

Top-up Policy Effective Date DD / MM / YY

Return Date (Policy Expiry Date) DD / MM / YY

Top-up Trip Length DD MM YY

# of days of Existing Coverage

Premium for Top-Up Coverage

Daily Rate _____ X # of Days _____ = $ _____ **C2**

PART 6 PREMIUM CALCULATION

Premium Subtotal A1 + B1 + C1 = $ _____ **P1**

Reduced Stability Option Surcharge

P1 _____ + Surcharge _____ % = _____ **P3**

Have you used Tobacco products within 24 months prior to your departure date? ◯ Yes ◯ No **+10%**

If you answer **"Yes"** to the tobacco usage question above Multiply P3 by 1.10 = $ _____ **P5**

If you apply with a companion you are eligible for a **5% companion premium saving.**

To apply the saving, please multiply P5 by 0.95 = $ _____ **P7**

Premium Subtotal A2 + B2 + C2 = $ _____ **P2**

Reduced Stability Option Surcharge

P2 _____ + Surcharge _____ % = _____ **P4**

Have you used Tobacco products within 24 months prior to your departure date? ◯ Yes ◯ No **+10%**

If you answer **"Yes"** to the tobacco usage question above Multiply P4 by 1.10 = $ _____ **P6**

If you apply with a companion you are eligible for a **5% companion premium saving.**

To apply the saving, please multiply P6 by 0.95 = $ _____ **P8**

All coverage is subject to a $250 US deductible per incident of claim unless you choose otherwise.

To eliminate this deductible check the box below			To eliminate this deductible check the box below		
$ 0 - No deductible	Multiply **P7** by 1.10	◯	$ 0 - No deductible	Multiply **P8** by 1.10	◯
To increase your deductible check the corresponding box below;			**To increase your deductible check the corresponding box below;**		
$1,000 US	Multiply **P7** by 0.90	◯	$1,000 US	Multiply **P8** by 0.90	◯
$2,500 US	Multiply **P7** by 0.80	◯	$2,500 US	Multiply **P8** by 0.80	◯
$5,000 US	Multiply **P7** by 0.70	◯	$5,000 US	Multiply **P8** by 0.70	◯
$10,000 US	Multiply **P7** by 0.55	◯	$10,000 US	Multiply **P8** by 0.55	◯

Subtotal after adjustment for deductible = $ **P9**

Subtotal after adjustment for deductible = $ **P10**

Total Premium Due P9 + P10 = $ _____

Minimum Premium $25.00 per applicant

PART 7 PAYMENT

◯ **Cheque** *Make payable to the Destination:Travel Group Inc. or your Broker* ◯ **Visa** ◯ **Mastercard**

Cardholder's Name

Cardholder's Number **Expiry Date** DD / MM / YY

**Your agent will be contacting you for the CVV# (3 digit number on the back of your card)*

Signature of Cardholder *(Only if different from applicants)* ✕

PART 8 MEDICAL DEFINITIONS

Assistance with activities of daily living means eating, bathing, using the toilet, changing positions (including getting in or out of bed or chair) and dressing.

Artery or vein disorder includes aneurysm, peripheral vascular disease (PVD), deep vein thrombosis (DVT), phlebitis, blood clots, venous insufficiency, carotid artery stenosis, arteriosclerosis.
It **does not** include varicose veins.

Bowel /stomach disorder includes ulcer, diverticulitis, irritable bowel syndrome (IBS), gastritis, ulcerative colitis, Crohn's disease, inflammatory bowel disease, gastrointestinal bleeds, bowel obstruction.
It **does not** include hemorrhoids, gastroesophaegeal reflux disease (GERD) or acid reflux.
It **does not** include the removal of polyps during a colonoscopy if this occurred once in the last 24 months and medical records indicate no further investigations, procedures or *treatment* are required or recommended.

Heart condition includes heart attack (myocardial infarction), arrhythmia, atrial fibrillation, heart murmur, irregular heart rate or beat, chest pain (angina), congestive heart failure, cardiomyopathy, congenital heart defect or any other condition relating to the heart.

Insurer means CUMIS General Insurance Company, a member of The Co-operators group of companies.

Lung condition includes chronic obstructive pulmonary disease (COPD), asthma, chronic bronchitis, chronic pneumonia, emphysema, tuberculosis, pulmonary fibrosis. It **does not** include seasonal allergies.

Minor condition describes a sickness or injury during the *stability* period which ended prior to the policy effective date and which did not require:
i. *treatment* for a period longer than 15 consecutive days; or
ii. more than one follow-up visit to a physician; or
iii. hospitalization, surgery, or referral to a specialist; and
iv. which ended at least 30 days prior to the departure date.

A chronic condition or any complication of a chronic condition **is not** considered a minor condition.

Neurological disorder means Alzheimer's disease or dementia, cerebral palsy, epilepsy, seizures, Parkinson's disease, Multiple Sclerosis or Lou Gehrig's disease (ALS).

Treatment / treated means a medical, therapeutic or diagnostic procedure prescribed, performed or recommended by a physician, including but not limited to prescription medication, surgery or investigative testing that results in a diagnosis of a specific medical condition. Does not include *minor conditions*.

Terminal illness means a medical condition for which, prior to your policy effective date, a physician gave a prognosis of eventual death within 24 months or palliative care was received.

PART 9 DEFINITION OF STABILITY (Your policy provides coverage for *stable* pre-existing conditions based on your plan classification)

Stable describes all medical conditions for which:
a) there has been no new *treatment*; and
b) there has been no alteration in any medication for the condition or in its usage or in its dosage, nor any alteration in *treatment* prescribed or recommended by a physician; and
c) there has been no signs or symptoms or new diagnosis; and
d) there has been no test results showing deterioration; and
e) there has been no hospitalization; and
f) there has been no referral to a specialist (made or recommended) and you are not awaiting the results of further investigations performed by any medical professional.

The following conditions are not considered stable:
a) any ***lung condition*** for which in the last 365 days you were prescribed or are taking **prednisone** for a period of more than 10 consecutive days;
b) any ***heart condition*** for which in the last 12 months you have used **nitroglycerin.**

The following are considered stable:
a) Routine (not prescribed by a physician) adjustment of insulin or Coumadin provided it was not first prescribed during the automatic stability period*.
b) The change from a brand named medication to a generic brand medication provided that the medication was not first prescribed during the automatic stability period and the usage or dosage has not changed.
c) a new medication prescribed solely as a result of a drug manufacturer's discontinuance of the original medication taken.
d) the decrease or elimination of a medication dosage by a physician, provided that it has changed more than 90 days prior to your policy effective date and has not had any effect on the stability of your medical condition for the 90 days prior to your departure/effective date.

*** See page 2 for automatic stability period for each plan classification**

PART 10 DECLARATION AND AUTHORIZATION

- I declare that on my policy effective date(s), I will meet the eligibility and plan classification requirements. Where I was unsure of my medical condition(s), I consulted with my physician and I understand that only my physician or I can establish my eligibility for this policy. I understand that in applying for coverage under this policy it is my responsibility to be aware of all my medical conditions. I understand that no statement made by me or any agent prior to or at the time of my application for insurance will be considered valid unless such statement has been documented and submitted in writing and accepted by Destination: Travel Group Inc. prior to the completion of this application. I understand the eligibility and plan classification requirements are material to the risk and form part of the application/policy and in consideration for the insurance for which I am applying.
- I acknowledge that any misrepresentations 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 I am found to be not eligible for this insurance, Allianz Global Assistance, on behalf of the *insurer* has the right to collect from me any monies paid out on my behalf.
- I understand that the insurance applied for will not become effective unless Destination: Travel Group Inc. / the *insurer* accepts this application and receives the full premium and a signed and dated copy of the application. Destination: Travel Group Inc. / the *insurer* has the right to decline any application without explanation. In the event that this application is not accepted, I will receive a full refund. I understand that certain terms, conditions, limitations and exclusions will apply and that only treatment for medical emergencies will be covered under this insurance.
- Medical Authorization in Case of Claim – I understand that the *insurer* and Allianz Global Assistance may investigate my claim. By signing this application, I 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 or examined me or who has knowledge or records of me or my health, to furnish to Destination: Travel Group Inc. / the *insurer* and to Allianz Global Assistance any or all information with respect to any illness, injury, medical history[1], consultations, medicines or treatment and copies of all hospital and/or medical records for the purpose of investigating my claim. Your personal information is also collected for the purpose of providing insurance services, claims analysis and payments. Please refer to the Privacy Information Notice contained in the policy document for further details.
- I hereby direct and authorize any other insurance plan under which I am covered for benefits to disclose personal information as may be necessary or to make payment in respect of my claim to the *insurer* and Allianz Global Assistance directly.
- This authorization remains valid until any claim pending or disputed under a policy issued as a result of this application is settled unless an applicable law specifies a shorter period, in which case it would expire within the period applicable under that law.
- I/We the undersigned consent to the *insurer* / Allianz Global Assistance providing Destination: Travel Group Inc. with any and all data related to claims information.
- A photocopy, electronic copy or fax of this authorization will be treated in the same manner as the original.
- If I/we am/are paying for this insurance by credit card, I/we authorize this transaction.

EACH APPLICANT MUST SIGN BELOW

SIGN HERE ✕ Signature Required

Applicant 1 Signature

Date of Application (DD/MM/YY) / /

SIGN HERE ✕ Signature Required

Applicant 2 Signature

Date of Application (DD/MM/YY) / /

[1] **IMPORTANT:** Medical History and Information excludes genetic tests*.
* Genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.

For Broker Use Only

Broker ID

Broker Name