Manulife

The McLennan Group Life Insurance Inc.

Travel Choice 2

MEDICAL QUESTIONNAIRE AND APPLICATION FOR TRAVELLING CANADIANS

Instructions

Medical questions help us to determine your eligibility and premium rate.

1. If you are under the age of 60 and meet the Eligibility requirements in Section A, Step 1, complete Section A Step 2 and Section B.
2. All other applicants must complete the entire Medical Questionnaire to apply for this insurance. If you are uncertain of your answers to any medical questions, please consult your doctor before completing this Medical Questionnaire.
3. All applications must be completed before the effective date of insurance.

Plan Information

Emergency Medical Single Trip Plan – Provides coverage for a single trip while travelling outside your province or territory of residence.

Emergency Medical Multi-Trip Plan – Provides coverage for any number of trips up to the option you selected (4, 10, 18, 30 or 60 days). Trips must be separated by a return to your province or territory of residence or Canada. The Multi-Trip Plans offer unlimited travel within Canada (excluding your province or territory of residence).

Travel Canada Emergency Medical Plan – Provides coverage for a single trip while travelling within Canada and outside your province or territory of residence.

Definitions

Italicized words have a specific meaning. Please refer to the following definitions when completing the Medical Questionnaire.

Change in medication means the medication dosage, frequency or type has been reduced, increased, or stopped and/or new medication(s) has/have been prescribed. **Exceptions:** the routine adjustment of Coumadin, warfarin or insulin (as long as they are not newly prescribed or stopped) and there has been no change in your *medical condition*; and a change from a brand name medication to a generic brand medication of the same dosage.

Medical condition means sickness, injury, disease or symptom, complication of pregnancy within the first thirty-one (31) weeks of pregnancy.

Pre-existing condition means a *medical condition* that existed before your effective date.

Stable – a *medical condition* is *stable* if all of the following apply during the specified stability period:

- there has not been any new symptom(s); and
- existing symptom(s) have not become more frequent or severe; and
- a physician has not determined that the *medical condition* has become worse; and
- no test findings have shown that the *medical condition* may be getting worse; and
- a physician has not provided, prescribed, or recommended any new medication or any *change in medication*; and
- a physician has not provided, prescribed, or recommended any investigative testing, new *treatment* or any change in *treatment*; and
- there has been no hospitalization or referral to a specialty clinic or specialist; and
- a physician has not advised referral to a specialist or further testing, and there has been no testing for which the results have not yet been received.

Treatment, Treated means hospitalization, prescribed medication (including medication prescribed "as needed"), medical, therapeutic, diagnostic or surgical procedure prescribed, performed or recommended by a licensed medical practitioner. **IMPORTANT:** Any reference to testing, tests, test results, or investigations 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.

Section A • Medical Questionnaire

NAME OF APPLICANTS (Last Name, First Name)

Applicant 1	Applicant 2

Step 1 • ARE YOU ELIGIBLE FOR COVERAGE ?

Eligibility. You must be at least 30 days of age and a Canadian resident covered by the Government Health Insurance Plan in your province or territory of residence for the entire duration of your trip. Coverage is NOT AVAILABLE under this policy or the Individual Medical Underwritten plan to any person who:

- is travelling against the advice of a physician;
- is diagnosed with a terminal illness or metastatic cancer;
- requires kidney dialysis;
- has been prescribed or used home oxygen in the last twelve (12) months;
- has had a bone marrow, stem cell or organ transplant (excluding cornea).

If you are not eligible to purchase this insurance, DO NOT complete this application.

Step 2 • YOUR DECLARATION – PLEASE READ CAREFULLY BEFORE SIGNING

I am eligible to apply to The Manufacturers Life Insurance Company (Manulife) for insurance under the Travel Choice 2 Travel Insurance policy. I declare that all the information I am providing on this application is true and complete. I understand the meaning of *treatment/treated*, as defined and used in this questionnaire.

I understand this coverage is subject to terms, conditions, limitations and exclusions (including the *pre-existing condition* exclusion); and, that this coverage may exclude or limit an amount payable if I have a claim. I understand that if I misrepresent any material information provided in this application, Manulife will void my policy and I will not be covered for any benefits under this policy.

I authorize any hospital, physician, other medical service provider or any other organization or person that has any records or knowledge of me or my health to release to the assistance and claims service provider and/or Manulife and its reinsurers any such information for the purpose of this application and contract and any subsequent claim.

Applicant 1 Signature	Applicant 2 Signature	(MM/DD/YYYY) Date Signed

Step 3 • DO YOU REQUIRE INDIVIDUAL MEDICAL UNDERWRITING?

You will need to answer the following questions to determine if you are eligible to purchase this insurance or our Individual Medical Underwriting Plan.If you are unsure of your answer to any medical question, consult your doctor before completing this application.

	APPLICANT 1	APPLICANT 2
1. Have you had a heart bypass, coronary angioplasty or heart valve surgery **more than ten (10) years ago**?	❑ Yes ❑ No	❑ Yes ❑ No
2. In the last **three (3) years**, have you been diagnosed with, taken or been prescribed medication, or been *treated* for **any two (2)** of the following? (if you only have one (1) of the following conditions, answer NO) • Heart condition; • Lung condition (except unrepeated prescription medications used for a single episode) (medication includes any puffer(s)/inhaler(s)); • Stroke/CVA (cerebrovascular accident) or mini-stroke/TIA (transient ischemic attack) (medication includes use of aspirin/Entrophen for this condition); • Diabetes (*treated* with medication and/or insulin); • Narrowed or blocked artery in the legs (also called Peripheral Vascular Disease).	❑ Yes ❑ No	❑ Yes ❑ No
3. In the last **two (2) years**, have you been: a) diagnosed with, taken or been prescribed medication, or been *treated* for heart failure or congestive heart failure; and/or b) prescribed or taken Lasix or furosemide or a water pill for ankle or leg swelling or water on the lungs?	❑ Yes ❑ No ❑ Yes ❑ No	❑ Yes ❑ No ❑ Yes ❑ No
4. In the last **twelve (12) months**, have you had: a) a new heart condition, or had an existing heart condition for which you had a *change in medication* or were hospitalized (as an inpatient or seen in the emergency department); and/or b) investigative testing or *treatment* for shortness of breath or chest pain; and/or c) a lung condition for which you were hospitalized (as an inpatient or seen in the emergency department) or for which you have been prescribed or taken prednisone; and/or d) cancer or received chemotherapy and/or radiotherapy and/or other *treatment*, other than routine follow-up, for cancer (except basal cell and squamous cell skin cancer, and breast cancer *treated* only with hormonal therapy)?	❑ Yes ❑ No ❑ Yes ❑ No ❑ Yes ❑ No ❑ Yes ❑ No	❑ Yes ❑ No ❑ Yes ❑ No ❑ Yes ❑ No ❑ Yes ❑ No
5. In the last **four (4) month**s, have you been prescribed or taken **six (6) or more** prescription medications? **Do not count** the following medications: hormone replacement therapy (thyroid or menopausal); drugs used for osteoporosis, or traveller's diarrhea; or any form of immunization. Do not count topical medications that go in your nose, ears or eyes or on your scalp or skin **except** any form of nitroglycerine or any drug(s) for angina.	❑ Yes ❑ No	❑ Yes ❑ No

If you must answer "**YES**" to ANY of the above questions, **you are not eligible** to purchase this insurance. Please call 1-866-991-9104 toll free if you wish to obtain a quote for our Individual Medical Underwriting plan for coverage of your *pre-existing conditions*.

If you answered "**NO**" **to ALL** of the above questions, you are eligible to purchase this insurance. Proceed to Step 4.

Step 4 • FIND YOUR RATE CATEGORY

Part 1 • SMOKING STATUS	Applicant 1	Applicant 2
1. In the last **two (2) years,** have you smoked cigarettes?	❑ Yes ❑ No	❑ Yes ❑ No

Proceed to Step 4 • Part 2

Part 2 • RATE QUALIFICATION	Applicant 1	Applicant 2
1. Have you **ever** been diagnosed with or *treated* for:		
a) a heart condition; and/or	❑ Yes ❑ No	❑ Yes ❑ No
b) any of the following conditions;	❑ Yes ❑ No	❑ Yes ❑ No
• Aortic aneurysm (including thoracic or abdominal aneurysm)		
• Cirrhosis of the liver;		
• Parkinson's disease;		
• Alzheimer's disease or other form of dementia?		
2. In the last **three (3) months**, have you been prescribed or taken a total of **three (3) or more** medications for high blood pressure (hypertension)?	❑ Yes ❑ No	❑ Yes ❑ No
3. In the last **five (5) years**, have you been diagnosed with, taken or been prescribed medication for, or been *treated* for any of the following:		
• Lung condition (except unrepeated prescription medications used for single episode) (medication includes any puffer(s)/inhaler(s));	❑ Yes ❑ No	❑ Yes ❑ No
• Stroke/CVA (cerebrovascular accident) or mini-stroke/TIA (transient ischemic attack) (medication includes use of aspirin/Entrophen for this condition);	❑ Yes ❑ No	❑ Yes ❑ No
• Diabetes (if *treated* with medication and/or insulin);	❑ Yes ❑ No	❑ Yes ❑ No
• Narrowed or blocked artery in the legs or in the neck?	❑ Yes ❑ No	❑ Yes ❑ No

If you answered "**YES**" to ANY questions in Step 4 • Part 2, you qualify for Rate Category C.
If you answered "**NO**" to ALL questions in Step 4 • Part 2, you must answer the questions in Step 4 • Part 3.

Part 3 • RATE QUALIFICATION	Applicant 1	Applicant 2
1. In the last **two (2) years**, have you been diagnosed with, taken or been prescribed medication, or *treated* for any of the following conditions?		
• Gastrointestinal bleeding **or** bowel obstruction or have had bowel surgery;	❑ Yes ❑ No	❑ Yes ❑ No
• Chronic bowel disorder (such as but not limited to Crohn's disease or Ulcerative colitis);	❑ Yes ❑ No	❑ Yes ❑ No
• Kidney disorder (including stones) **or** Liver disorder **or** Pancreatitis;	❑ Yes ❑ No	❑ Yes ❑ No
• Gallbladder disorder (including stones. Not applicable if gallbladder has been removed.)	❑ Yes ❑ No	❑ Yes ❑ No
2. In the last **two (2) years**, have you been diagnosed with, and/or *treated* by a Hematologist or an Internist for a blood disorder?	❑ Yes ❑ No	❑ Yes ❑ No
3. Are you over 70, **and** have you had a fall for which you sought medical attention in the last **six (6) months**?	❑ Yes ❑ No	❑ Yes ❑ No
4. In the last **six (6) months**, have you received advice or *treatment* **more than twice** in the emergency room of a hospital ?	❑ Yes ❑ No	❑ Yes ❑ No

If you answered "**YES**" to ANY question in Step 4 • Part 3, you qualify for Rate Category B.
If you answered "**NO**" to ALL questions in Step 4 • Part 3, you qualify for Rate Category A.

RATE CATEGORY

I am 60 years of age or older and based on my answers above, I qualify for the following rate category:

Applicant 1: ❑ A ❑ B ❑ C **Applicant 2:** ❑ A ❑ B ❑ C

IMPORTANT: The rate category you qualify for determines the *pre-existing condition* exclusion that applies to your coverage. The *pre-existing condition* exclusions are detailed below.

NOTE: If you prefer to have your *pre-existing conditions* covered, call 1-866-991-9104 toll free if you wish to obtain a quote for our Individual Medical Underwriting Plan. You may be provided with with a quote for a **single-trip emergency medical plan and have your *pre-existing conditions* covered.**

Rate Categories and Pre-existing Condition Exclusion

The *pre-existing condition* exclusion which applies to your Rate Category. All applicants 59 years of age or less automatically qualify for Rate Category A.

Rate Category A. We will not pay any expenses relating to:

- a *pre-existing condition* that is not *stable* in the **three (3) months** before your effective date; and/or
- your heart condition if, in the **three (3) months** before your effective date, any heart condition has not been *stable* or you have taken any form of nitroglycerine for the relief of angina pain; and/or
- your lung condition if, in the **three (3) months** before your effective date, any lung condition has not been *stable* or you required *treatment* with oxygen or prednisone for your lung condition.

Rate Categories B and C. We will not pay any expenses relating to:

- a *pre-existing condition* that is not *stable* in the **six (6) months** before your effective date; and/or
- your heart condition if, in the **six (6) months** before your effective date, any heart condition has not been *stable* or you have taken any form of nitroglycerine for the relief of angina pain; and/or
- your lung condition if, in the **six (6) months** before your effective date, any lung condition has not been *stable* or you required *treatment* with oxygen or prednisone for your lung condition.

Section B • Insurance Application

APPLICANTS

LAST NAME, FIRST NAME					DATE OF BIRTH
1. Applicant 1					(MM/DD/YYYY)
HOME ADDRESS Street	Apt No.	City	Province	Postal Code	
HOME PHONE # ( )	**WORK PHONE #** ( )	**EMAIL** (optional)	**COUNTRY OF DESTINATION**		**PHONE # AT DESTINATION** ( )
LAST NAME, FIRST NAME					**DATE OF BIRTH**
2. Applicant 2					(MM/DD/YYYY)
HOME ADDRESS Street	Apt No.	City	Province	Postal Code	
HOME PHONE # ( )	**WORK PHONE #** ( )	**EMAIL** (optional)	**COUNTRY OF DESTINATION**		**PHONE # AT DESTINATION** ( )

TRAVEL INFORMATION

(Select your Emergency Medical plan)	Applicant 1	Applicant 2
1. Multi-Trip Plan – covers multiple trips for 365 days	❑ 4 days ❑ 10 days ❑ 18 days ❑ 30 days ❑ 60 days	❑ 4 days ❑ 10 days ❑ 18 days ❑ 30 days ❑ 60 days
	Effecitve Date (MM/DD/YYYY)	Effecitve Date (MM/DD/YYYY)
2. Single Trip or Top-Up Duration	Departure Date (MM/DD/YYYY)	Departure Date (MM/DD/YYYY)
	Effecitve Date* (MM/DD/YYYY)	Effecitve Date* (MM/DD/YYYY)
	Expiry Date (MM/DD/YYYY)	Expiry Date (MM/DD/YYYY)
	Total # of days**	Total # of days**

* Coverage will begin on the effective date you choose. If you are adding this insurance as a Top-Up to an existing coverage, the Effective Date will be the day after your existing coverage terminates.
** Count your Effective Date, your Expiry Date and the days in between.

SAVINGS OPTION

Deductible Savings: All published rates include a zero deductible. Not applicable to Travel Canada Emergency Medical Plan.						Savings Applied
Deductible ($ USD)	$0	$500	$1,000	$5,000	$10,000	
Savings Amount	0%	15%	20%	35%	50%	%
Travel Canada Emergency Medical Plan*: Cannot be combined with a Deductible Savings.						50%

* Entire trip must be in Canada.

CALCULATE YOUR PREMIUM

	Applicant 1	Applicant 2
1. Rate Category		
2. Multi-Trip Premium – (premium for trip length you selected)	+$	+$
3. Single Trip or Top-Up Premium (number of days* X daily rate applicable to the TOTAL NUMBER OF DAYS IN YOUR TRIP)	+$	+$
4. **SUBTOTAL**	=$	=$
5. Savings Option – (Line 4 X % selected in SAVINGS OPTION)	$	$
6. Travel Companion Savings – (Line 4 X 5% for each applicant, if applicable)	$	$
7. TOTAL SAVINGS – (ADD Lines 5 and 6)	$	$
8. **SUBTOTAL** (line 4 LESS line 7)	$	$
9. Smoker's Surcharge – if you are age 60 or over and have smoked cigarettes in the last two (2) years prior to the date of this application, calculate Line 4 X 10%	$	$
10. **TOTAL PREMIUM per Applicant** (ADD line 8 and line 9)	$	$
11. **TOTAL PAYMENT (submitted for Applicant 1 PLUS Applicant 2)**	$	

* use "Total # of Days' under TRAVEL INFORMATION

Payment Method: ❑ Visa ❑ MasterCard ❑ Cheque

Cardholder's Name

Cardholder's Signature

Credit Card Number

Expiry Date

Note: Coverage will not take effect if your credit card number is invalid or payment is rejected for any reason.

Mail this application with your payment payable to CanAm Insurance PO Box 62, Station A, Windsor ON N9A 6J5.

Advisor's Report • For Advisor/Agent Use Only

You confirm that you have disclosed the following information to the applicant:

- the name of the company or companies you represent
- that you receive commissions for the sale of life and accident and sickness insurance products and may receive bonuses, invitations to conferences or other incentives; and
- any conflicts of interest you may have with respect to this transaction.

Your name (first, middle initial, last)	Advisor code	Signature

Agent – Please complete this section

Agent name	Telephone number	Fax number	Agent selling code
The McLennan Group Life Insurance Inc.	1 (866) 943-5997	(519) 974-5885	578100
Company name and address		**Email address**	**Resource centre code**
The McLennan Group Life Insurance Inc. PO Box 62, Station A, Windsor ON N9A 6J5		tmgtravel@canamins.com	TMG

Travel Choice 2 Travel Insurance is offered through The Manufacturers Life Insurance Company.