Manulife

The McLennan Group Life Insurance Inc.

Travel Choice 2

Medical Questionnaire and Application Form

Instructions

Medical questions help us to determine your eligibility and premium rate if you are age 60 or over.

1. If you are under the age of 60, proceed to Part C to complete the application.
2. All other applicants must complete the medical questionnaire in Part A and the Applicant's Declaration in Part B 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 or 30 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 or frequency 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.

Hospital means a facility that is licensed as a *hospital* where in-patients receive medical care and diagnostic and surgical services under the supervision of a staff of physicians with 24-hour care by registered nurses. A clinic, an extended or palliative care facility, a rehabilitation establishment, an addiction centre, a convalescent, rest or nursing home, home for the aged or health spa is not a *hospital*.

Medical condition means injury, illness, disease, or symptom, complication of pregnancy within the first thirty-one (31) weeks of pregnancy, or a mental or emotional disorder that requires admission to a *hospital*, or acute psychosis.

Medical emergency means a sudden unforeseen occurrence of symptoms, injury, illness, or disease which requires immediate *treatment*.

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:

- you have not had any new symptom(s); and
- existing symptom(s) have not become more frequent or severe; and
- your physician has not determined that your *medical condition* has become worse; and
- no test findings have shown that your *medical condition* may be getting worse; and
- you have not received, been prescribed, taken or had a physician recommend any new medication, or any *change in medication*; and
- you have not received, been prescribed or had a physician recommend any new *treatment* or any change in *treatment*; and
- you have not been *hospitalized* or referred to a specialty clinic or specialist; and
- your physician has not advised you to see a specialist or to have further tests, and you have not undergone testing for which you have not yet received the results.

Treatment means a medical, therapeutic or diagnostic procedure prescribed, performed or recommended by a licensed medical practitioner, including but not limited to prescribed medication, investigative testing and surgery related to any illness, injury or symptom.

Part A • Medical Questionnaire

NAME OF APPLICANTS (Last Name, First Name)

Applicant 1	Applicant 2

STEP 1 • ELIGIBILITY	Applicant 1	Applicant 2
1. Have you been advised by a physician not to travel at this time?	❑ Yes ❑ No	❑ Yes ❑ No
2. Do you require kidney dialysis?	❑ Yes ❑ No	❑ Yes ❑ No
3. Have you **ever** had a bone marrow or organ transplant (excluding corneal transplant)?	❑ Yes ❑ No	❑ Yes ❑ No
4. Have you had a heart bypass, angioplasty or heart valve surgery **more than ten (10) years** ago?	❑ Yes ❑ No	❑ Yes ❑ No
5. In the last **five (5) years**, have you been diagnosed with and/or had *treatment* for metastatic cancer?	❑ Yes ❑ No	❑ Yes ❑ No
6. In the last **six (6) months**, have you 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
7. In the last **twelve (12) months**, have you been prescribed or taken prednisone or oxygen or been *hospitalized* (as an in-patient or seen in the emergency department) for a lung condition?	❑ Yes ❑ No	❑ Yes ❑ No
8. In the last **two (2) years**, have you: a) been prescribed or taken Lasix or furosemide for any reason? b) had congestive heart failure?	❑ Yes ❑ No	❑ Yes ❑ No
9. In the last **twelve (12) months**, have you been *hospitalized* (as an in-patient or seen in the emergency department) for a heart condition?	❑ Yes ❑ No	❑ Yes ❑ No
10. In the last **four (4) months**, 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
11. In the last **three (3) years**, have you been diagnosed with and/or had *treatment* for and/or been *hospitalized* (as an in-patient or seen in the emergency department) and/or been prescribed or taken medication for any **two (2)** of the following? (if you only have **one (1)** of the following conditions, answer **NO**) ■ Heart condition ■ Lung condition (medication includes any puffer(s)/inhaler(s), **except** a single unrepeated prescription medication used for a single episode) ■ Diabetes (treated with medication and/or insulin) ■ Stroke/CVA (cerebrovascular accident) or mini-stroke/TIA (transient ischemic attack) (including use of aspirin/Entrophen for this condition) ■ Narrowed or blocked artery in the legs (also called Peripheral Vascular Disease) ■ Alzheimer's disease, or any other form of dementia	❑ Yes ❑ No	❑ Yes ❑ No

ELIGIBILITY REQUIREMENT: If you must answer "**YES**" to ANY of the preceding questions, you are **not eligible** to purchase this insurance. **DO NOT** complete this questionnaire. Please contact CARP 1-866-991-9104 toll free or 1 (519) 251-7295 if you wish to obtain a quote for our Individual Medical Underwriting plan. Continue to Step 2 if you are eligible to purchase this insurance.

STEP 2 • FIND YOUR RATE CATEGORY

RATE QUALIFICATION • Part 1	Applicant 1	Applicant 2
1. In the last **five (5) years**, have you been diagnosed with and/or had *treatment* and/or been *hospitalized* (as an in-patient or seen in the emergency department) and/or been prescribed or taken medication for any of the following? ■ Heart condition ■ Stroke/CVA (cerebrovascular accident) or mini-stroke/TIA (transient ischemic attack) (including use of aspirin/Entrophen for this condition) ■ Aneurysm ■ Narrowed or blocked artery in the legs (also called Peripheral Vascular Disease) ■ Diabetes (if treated with medication and/or insulin) ■ Lung condition (medication includes any puffer(s)/inhaler(s), **except** a single unrepeated prescription medication used for a single episode) ■ Cirrhosis of the liver ■ Alzheimer's disease, or any other form of dementia, or Parkinson's disease	❑ Yes ❑ No	❑ Yes ❑ No
2. In the last **five (5) years**, have you smoked or used any tobacco products **and** been prescribed or used any puffer(s)/inhaler(s)?	❑ Yes ❑ No	❑ Yes ❑ No
3. In the last **six (6) months**, have you received advice or *treatment* for a *medical emergency* **more than once** in the emergency room of a *hospital*?	❑ Yes ❑ No	❑ Yes ❑ No
4. 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) and/or a heart condition?	❑ Yes ❑ No	❑ Yes ❑ No

If you answered "**YES**" to ANY of the questions in Step 2 • Part 1, you qualify for Rate Category C.
If you answered "**NO**" to ALL of the questions in Step 2 • Part 1, you must answer the question in Step 2 • Part 2.

RATE QUALIFICATION • Part 2	Applicant 1	Applicant 2
1. In the last **two (2) years**, have you been diagnosed with and/or received *treatment* for and/or been *hospitalized* (as an in-patient or seen in the emergency department) and/or been prescribed or taken prescription medication for any of the following conditions?		
■ Bowel obstruction or surgery	❑ Yes ❑ No	❑ Yes ❑ No
■ Diverticular disorder requiring prescription medication or surgery	❑ Yes ❑ No	❑ Yes ❑ No
■ Gastrointestinal bleeding	❑ Yes ❑ No	❑ Yes ❑ No
■ Bleeding or perforated ulcer(s)	❑ Yes ❑ No	❑ Yes ❑ No
■ Chronic bowel disorder	❑ Yes ❑ No	❑ Yes ❑ No
■ Liver disorder	❑ Yes ❑ No	❑ Yes ❑ No
■ Pancreatic disorder	❑ Yes ❑ No	❑ Yes ❑ No
■ Kidney disorder (including stones)	❑ Yes ❑ No	❑ Yes ❑ No
■ Gallbladder disorder (including stones; if gallbladder has been removed answer **NO**)	❑ Yes ❑ No	❑ Yes ❑ No

If you answered "**YES**" to **two (2) or more** conditions listed in Step 2 • Part 2, you qualify for Rate Category C.
If you answered "**YES**" to **one (1)** condition listed in Step 2 • Part 2, you qualify for Rate Category B.
If you answered "**NO**" to ALL of the conditions listed in Step 2 • Part 2, you must answer the questions in Step 2 • Part 3.

RATE QUALIFICATION • Part 3	Applicant 1	Applicant 2
1. In the last **two (2) years**, have you been diagnosed with, and/or been *hospitalized* (as an in-patient or seen in the emergency department), and/or received *treatment*, and/or been prescribed medication by a Hematologist or an Internist for a blood disorder?	❑ Yes ❑ No	❑ Yes ❑ No
2. In the last **twelve (12) months**, have you been prescribed or used a puffer/inhaler?	❑ Yes ❑ No	❑ Yes ❑ No
3. In the last **twelve (12) months**, have you been diagnosed with or received *treatment* for cancer, other than routine follow-up (**except** basal cell and squamous cell skin cancer, and breast cancer treated only with hormonal therapy)?	❑ Yes ❑ No	❑ Yes ❑ No
4. 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

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

RATE QUALIFICATION • Part 4	Applicant 1	Applicant 2
1. In the last **two (2) years**, have you smoked cigarettes?	❑ Yes ❑ No	❑ Yes ❑ No

If you answered "**YES**" to the question in Step 2 • Part 4, you qualify for Rate Category A.
If you answered "**NO**" to the question in Step 2 • Part 4, you qualify for Rate Category A+.

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.

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

Pre-existing Condition Exclusion

The *pre-existing condition* exclusion which applies to you depends on your Rate Category as determined by the answers to the medical questions in Part A. All applicants 59 years of age or less automatically qualify for Rate Category A. **NOTE:** For the Travel Canada *Emergency* Medical plan, *no pre-existing condition* exclusion applies.

Rate Categories A+ and 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 Category B. 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.

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

- a *pre-existing condition* that is not *stable* in the **twelve (12) months** before your effective date; and/or,
- your heart condition if, in the **twelve (12) 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 **twelve (12) months** before your effective date, any lung condition has not been *stable* or you required *treatment* with oxygen or prednisone for your lung condition.

Part B • Applicant's Declaration – Please read carefully before signing

Declaration. I apply to The Manufacturers Life Insurance Company (Manulife Financial) for insurance under the Manulife Financial Travel Insurance policy. I declare that all the information I have provided on this application form, together with the Health Declaration originally attached hereto, is true and complete. I understand that this coverage is subject to terms, conditions, limitations and exclusions (including the *pre-existing condition* exclusion) and 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 Financial 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 Financial and its reinsurers any such information for the purpose of this application and contract and any subsequent claim.

Notice on Privacy and Confidentiality. The specific and detailed information requested on the application form is required to process the application. To protect the confidentiality of this information, Manulife Financial will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife Financial employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Affinity Markets, Manulife Financial, P.O. Box 4213, Stn A, Toronto, Ontario M5W 5M3.

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

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**	**CARP**

Part C • 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 2. Applicant 2				**DATE OF BIRTH** (MM/DD/YYYY)
HOME ADDRESS Street	Apt No.	City	Province	Postal Code
HOME PHONE # ( )	**WORK PHONE #** ( )	**EMAIL** (optional)	**COUNTRY OF DESTINATION**	**PHONE # AT DESTINATION** ( )

COVERAGE SELECTION

MULTI-TRIP DURATION and EFFECTIVE DATE

Covers multiple trips during a 365-day period. **SELECT YOUR TRIP LENGTH:** ❑ **4 days** ❑ **10 days** ❑ **18 days** ❑ **30 days**

EFFECTIVE DATE: _____ (MM/DD/YYYY)

SINGLE-TRIP DURATION

Departure Date*	(MM/DD/YYYY)
Return Date	
Total # of days in your trip[1]	

* Must be within 180 days of purchase

[1] Count the day you leave and the day you return.

TOP-UP NOTE: If you are 60 or older, you must complete the Medical Questionnaire to determine your Rate Category.

TOP-UP DURATION

Top-Up Effective Date*	(MM/DD/YYYY)
Total # of days in your trip[1]	
Subtract # of days already covered under your policy	–
Equals Total Top-Up days	=

CALCULATE YOUR PREMIUM

Premium due for your coverage is based on the plan you are purchasing, your age, the Rate Category you qualify for and trip duration.

EMERGENCY MEDICAL

Applicant #	Rate Category	Total Emergency Medical Premium: Single-Trip or Top-Ups (# of days x daily rate applicable to your full trip length)[2]	Total Emergency Medical Premium: Multi-Trip (Rate for the trip length you select)
1		$	$
2		+ $	+ $
	Total Premium (sum premium rates of each applicant)	= $ **Line A**	= $ **Line A**

[2] For Top-Up Premium use the daily rate applicable to the **TOTAL NUMBER OF DAYS IN YOUR TRIP**.

SAVINGS OPTIONS

Savings Applied

Deductible Savings: All published rates include a zero deductible. Not applicable to Travel Canada.

Deductible ($ USD)	$0	$500	$1,000	$5,000	$10,000	
Savings Amount	0%	15%	20%	35%	50%	%

50% Travel Canada Emergency Medical Plan: Cannot be combined with a Deductible Savings.

Calculate Savings (% x Line A) = $ **Line B**

TOTAL PREMIUM

Emergency Medical Premium (Line A minus Line B)	= $ **Line C**
Travel Companion Savings (Line C x 5%)	= $ **Line D**
Total Payment (Line C minus Line D)	= $

If you need help with your premium calculation, please contact your broker/advisor.

Payment Option: ❑ 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.

Plans underwritten by The Manufacturers Life Insurance Company.