Travelance Insurance Eligibility Questionnaire

IMPORTANT

- You and only you are responsible for the answers you give on this questionnaire
- If you are unsure of your medical history, ask your doctor
- If you do not meet the eligibility requirements, you cannot buy this insurance
- Read your policy before you travel and make sure you understand it
- If you provide any incorrect information you will not have coverage
- Call the underwriter at 1-888-831-2222 if:
  - you do not understand the policy or this questionnaire
  - your health changes before you depart
  - you have any questions

Use this questionnaire if:

a) You are **under 70 years old** and want to insure a trip cost of more than **$25,000**;

b) You are **over 69 years old** and want to insure a trip cost of more than **$15,000**;or

c) You are **over 69 and under 90 years old** and want to buy the **All Inclusive Worldwide Plan** for more than **16 travel days.**

How can we reach you?

Name: ______________________________ Email Address: ______________________________

Canadian Address: ____

Telephone Number: ______________________ Mobile Number: ______________________________

Date of Birth: (mm/dd/yy) ____ / ____ / ____

Part 1

Check Yes or No for each condition for which you were diagnosed with or **Treated** (see definition below) in the **2 years** before your departure date in the Medical Conditions Table below.

MEDICAL CONDITIONS TABLE

a) Coronary artery disease, heart attack or angina .... Yes ☐ No ☐

b) Valvular heart disease, abnormal heartbeat, arrhythmia or use of a pacemaker .... Yes ☐ No ☐

c) A lung or respiratory condition for which daily medication has been prescribed (including inhalers) .... Yes ☐ No ☐

d) Diabetes that requires medication (including insulin) .... Yes ☐ No ☐

e) Stroke or mini-stroke (TIA) .... Yes ☐ No ☐

f) Aneurysm .... Yes ☐ No ☐

g) Blood clots .... Yes ☐ No ☐

h) Gastro-intestinal bleed .... Yes ☐ No ☐

i) Parkinson's disease .... Yes ☐ No ☐

If you answered **YES** to **2 or more** conditions above **you cannot buy this insurance**.

If you answered **NO** to every condition above proceed to **Part 2.**

If you answered **YES** to **1** condition above:

Were you admitted to hospital for this condition in the **2 years** before your departure date? .... Yes ☐ No ☐

If you answered **YES** then **you cannot buy this insurance.**

If you answered **NO** proceed to **Part 2.**

Treat, Treated or **Treatment** – means a medical, therapeutic or diagnostic procedure prescribed, performed or recommended by a physician, including but not limited to prescribed medication, investigative testing and surgery. Do not count aspirin, acetaminophen or ibuprofen as **Treatment.**

Name: ______________________________

Part 2

Read questions 1 to 5 and check Yes or No.

1. Do you have a terminal illness? .... Yes ☐ No ☐
2. Has a doctor advised you not to travel? .... Yes ☐ No ☐
3. Do you have metastatic cancer? .... Yes ☐ No ☐
4. In the **2 years** before your departure date:
   a. Were you admitted to hospital due to:
      i. Diverticulitis .... Yes ☐ No ☐
      ii. Peripheral vascular disease (excluding varicose veins) .... Yes ☐ No ☐
      iii. Bowel obstruction .... Yes ☐ No ☐
      iv. Ulcerative colitis or Crohn's disease .... Yes ☐ No ☐
      v. Liver condition .... Yes ☐ No ☐
      vi. Alzheimer's disease or dementia .... Yes ☐ No ☐
      vii. Any seizure disorder .... Yes ☐ No ☐
      viii. Kidney stones .... Yes ☐ No ☐
      ix. Gallbladder disease and/or gall stones .... Yes ☐ No ☐
      x. Cancer .... Yes ☐ No ☐

   b. Have you lived in a retirement home, nursing home, assisted living home, convalescent home, hospice or rehabilitation centre that assists you daily with your mobility or medications (do not include a one-time temporary stay at a rehabilitation centre of no more than 6 weeks)? .... Yes ☐ No ☐
   c. Have you had chemotherapy, radiation therapy or any surgery for cancer (excluding the removal of skin lesions other than malignant melanoma)? .... Yes ☐ No ☐
5. In the **2 years** before your departure date were you diagnosed or **Treated** (see definition) for:
   a. Congestive heart failure? .... Yes ☐ No ☐
   b. Kidney failure requiring dialysis? .... Yes ☐ No ☐
   c. A lung condition requiring home oxygen? .... Yes ☐ No ☐

If you answered **YES** to **ANY** question in Part 2, **you cannot buy this insurance**.

If you answered **NO** to **ALL** questions in Part 2, complete **Part 3.**

Name: ____________________

Part 3 Declaration/Authorization: You must read, initial and sign this declaration; otherwise we cannot accept the questionnaire.

I am the applicant. By signing this declaration I take responsibility for my answers on this questionnaire. I declare that I am eligible to buy this insurance and that the information I give is accurate. If I was not sure about the medical information needed for this questionnaire, I checked it with my doctor before signing. **(initial)** ☐

I agree that if I provide incorrect information on my questionnaire or if I am not eligible for the plan I bought, Old Republic Insurance Company of Canada/Reliable Life Insurance Company ("the Company") will void my policy and cancel my coverage. **(initial)** ☐

If my health changes and this affects my eligibility before any trip departure date, I will notify the Company. **(initial)** ☐

I understand that I must read my policy before I travel because it contains the terms, conditions, limitations and exclusions that apply to me and my trip. **(initial)** ☐

In the event of a claim or a medical emergency while on my trip, I authorize and direct any physician, health care practitioner, hospital, 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 give the Company or its agents all the information they have with respect to my health and my treatment, including copies of hospital and/or medical records, for the purpose of adjudicating my claim. I authorize the Company to collect, use and disclose this information to authorized third parties, including its reinsurers and service providers, as it relates to the administration of services or benefits under this policy. I understand that the purpose for the collection, use, and disclosure of medical records and other personal and insurance information is to allow the Company and/or its third parties to provide assistance services and adjudicate/manage my claim. This authorization takes effect on the date specified below. I understand I may revoke this consent in writing, however, in doing so, I may be jeopardizing my entitlement to insurance coverage **(initial)** ☐

Signature: ____________________ Date: ____________

We cannot accept this questionnaire unless you complete it, initial and sign it, and pay the premium.

A copy of this completed questionnaire should be retained for your records.

Read your policy upon receipt. It contains exclusions, conditions and limitations. It is important that you understand what you are covered for. Within 10 days after you receive your policy and before you leave on your trip, you may cancel your policy for any reason and get a full refund.

For Agents Use Only: Submit a copy of this completed questionnaire within 48 hours to the Company via the online portal, fax (877-592-4448) or mail.

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