

You must be a Canadian resident in order to purchase TravelStar Travel insurance. Plans are not available in Quebec and New Brunswick.

A. Eligibility for Emergency Medical Coverage		
You ("you" refers to any person listed on this application) are NOT eligible for coverage if you answer yes to any of the following questions.	Applicant 1	Applicant 2
1. Are you awaiting tests or medical treatment for a heart condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you have a surgically untreated vascular aneurysm?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you been diagnosed with a congestive heart failure (CHF)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you have an implantable cardioverter defibrillator (ICD)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Were you diagnosed; did you receive new medical treatment (e.g. consultation, tests or prescription drugs); or had a change in your medical treatment (e.g. a stop, start or dosage change to a prescription drug, other than a dosage change of Coumadin or Warfarin) for any of the following heart or vascular conditions in the last twelve (12) months? a) heart transplant; d) peripheral vascular disease; b) atrial flutter; e) stroke/TIA; or c) atrial/ventricular fibrillation; f) blood clots;	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do you have diabetes that is treated with insulin AND take prescription medication for a heart condition (excluding medication to treat high cholesterol or high blood pressure)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Do you use home oxygen or take an oral steroid to treat a lung condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Are you currently being treated for cancer, excluding breast or prostate cancer treated exclusively with hormone therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Were you diagnosed; did you receive new medical treatment (e.g. consultation, tests or prescription drugs); or had a change in your medical treatment (e.g. a stop, start or dosage change to a prescription drug) for, any of the following conditions in the last twelve (12) months? a) liver failure; b) AIDS; or c) GI bleed; d) terminal illness;	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you had any of the following procedures in the last twelve (12) months? a) valve surgery or replacement; b) kidney dialysis; or c) organ, stem cell or bone marrow transplant;	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Are you seventy (70) years of age or older and require assistance from another person(s) with activities of daily living (ADL)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

B. Medical Questionnaire (This section is ONLY for applicants age 60 and over)		
	Applicant 1	Applicant 2
1. Have you ever suffered from, been diagnosed with, received treatment for, or been prescribed drugs for any of the following medical conditions, or undergone any of the following medical procedures:	<i>If answering "YES", please indicate the specific condition(s) on the left.</i>	
a) <input type="checkbox"/> Heart/Cardiovascular Disease or Condition, <input type="checkbox"/> Heart Attack, <input type="checkbox"/> Angina, <input type="checkbox"/> Irregular Heartbeat, <input type="checkbox"/> Heart Surgery, <input type="checkbox"/> Coronary Angioplasty, <input type="checkbox"/> Stenting, <input type="checkbox"/> Bypass, <input type="checkbox"/> Valve Replacement or Valve Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) <input type="checkbox"/> Stroke/TIA, <input type="checkbox"/> Blood Clots, <input type="checkbox"/> Aneurysm, <input type="checkbox"/> Peripheral Vascular Disease, <input type="checkbox"/> Carotid Stenosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Chronic Lung Disease (e.g. Chronic Obstructive Pulmonary Disease (COPD)/Emphysema/Persistent Asthma)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) <input type="checkbox"/> Bone Marrow or <input type="checkbox"/> Organ Transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the past two years have you suffered from, been diagnosed with, received treatment for or been prescribed drugs for any of the following medical conditions:		
a) Cancer (excluding Basal Cell Carcinoma)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Pancreatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) <input type="checkbox"/> Chronic Kidney Disease, <input type="checkbox"/> Liver Disease, <input type="checkbox"/> Gastrointestinal Disorders (e.g. Ulcers, GI Bleed, Bowel Obstruction, Hepatitis, Crohn's Disease, Colitis or Diverticular Disease)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) <input type="checkbox"/> Epilepsy, <input type="checkbox"/> Seizures, or <input type="checkbox"/> Syncope	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Hospitalized as a result of a fall	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) <input type="checkbox"/> Multiple Sclerosis (M.S.), <input type="checkbox"/> Lou Gehrig's Disease, <input type="checkbox"/> Parkinson's Disease, <input type="checkbox"/> Dementia or Alzheimer's	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has it been more than 30 months since your last checkup with a physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No