Visitors to Canada

Detailed medical questionnaire

Allianz

Global Assistance

Underwritten by CUMIS General Insurance Company, a member of The Co-operators group of companies, and administered by Allianz Global Assistance. Allianz Global Assistance is a registered business name of AZGA Service Canada Inc.

How to complete this form: Complete one form for each person applying for insurance.

- Answer all questions on the form.
- If you're unsure about your answers, please talk to your physician first.
- Applicant, legal guardian or power of attorney must sign and date the form.
- If you have any questions about this form, you can reach us toll-free at: 1-888-298-8151.
- If your application is missing information or isn't signed and dated, we'll have to follow up with you or your agent/broker and it will take longer to process your application.

For the complete terms, conditions, limitations and exclusions please refer to the policy.

Mail, fax or email it back to us
AZGA Service Canada Inc.
o/a Allianz Global Assistance
Underwriting Department
P.O. Box 277
Waterloo, Ontario N2J 4A4
Canada

Fax: **1-866-256-2377** or 416-340-0790

Email: **directuw@allianz-assistance.ca**

Eligibility

1. Coverage is NOT AVAILABLE to any individual who, as of the effective date:
   a) has been diagnosed with a terminal illness; or
   b) has been diagnosed with stage 3 or 4 cancer; or
   c) has received treatment for any cancer (other than basal or squamous cell skin or breast cancer treated only with hormone therapy) in the past 3 months; or
   d) requires assistance with activities of daily living as the result of a medical condition or state of health.

You are eligible to apply for coverage if you meet the eligibility requirements stated.

Do you confirm that you are eligible to apply? ☐ NO ☐ YES

Information about you

Last name (please print) | First name | MM/DD/YYYY Date of birth

Previous Allianz Global Assistance policy #'s (if known)

Street | Apt # | City

Province | Postal code | Phone | Fax | E-mail

Information about your agent – Only complete this section if you have an agent

Who should we contact? ☐ you ☐ your agent

Agent's name | Agent's code

Send correspondence by

☐ Fax ☐ E-mail | Attention

Ready to begin?
Please go to the next page to get started. ▶

Applicant's name (please print) | **Date** MM/DD/YYYY

Details about your travel plans

Destination (city, state or country) | Departure date MM/DD/YYYY | Return date MM/DD/YYYY

What type of coverage do you want?

Visitors to Canada Plan

☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $100,000 ☐ $150,000 ☐ $300,000

Your medical Information

1. Have you smoked or used any tobacco products in the last 5 years? ☐ **NO** ☐ **YES**
2. When was the last visit to your physician or medical clinic? (MM/DD/YYYY)

   Reason for visit/Results (diagnosis, medications prescribed, follow-up appointments, investigations or treatments, surgery recommended or scheduled)

Height _____ ☐ ft/ in ☐ cm

Weight _____ ☐ lbs ☐ kg

3. Have you been advised by a physician to have a test, investigation or surgery that you haven't had yet?
   ☐ **NO** ☐ **YES** → please provide details

Your medical conditions—Check YES or NO for each group of conditions

Check YES if you've **ever** had symptoms, investigations or treatment for any of the conditions in the group, then check the box beside the specific condition you have. If you have more than one condition, check the box for **every** condition that you have.

Auto-immune disorder

☐ **NO** ☐ **YES – please check all that apply**

- ☐ Lou Gehrig's disease
- ☐ scleroderma
- ☐ acquired immune deficiency (AIDS) or human immunodeficiency virus (HIV)
- ☐ multiple sclerosis
- ☐ systematic lupus erythematosis
- ☐ sarcoidosis any location
- ☐ myasthenia gravis
- ☐ other _____

Blood disorder

☐ **NO** ☐ **YES – please check all that apply**

- ☐ idiopathic thrombocytopenic purpura (ITP)
- ☐ hemochromatosis
- ☐ sickle-cell anemia
- ☐ anemia
- ☐ thrombophilia (hypercoagulability)
- ☐ hemophilia (hypocoagulability)
- ☐ spleen removed
- ☐ other _____

High blood pressure, cholesterol or water retention

☐ **NO** ☐ **YES – please check all that apply**

- ☐ high blood pressure
  - ☐ not taking medication
  - ➥ taking medication ☐ 1 ☐ 2 ☐ 3+ medications
- ☐ high cholesterol
  - ☐ not taking medication
  - ➥ taking medication ☐ 1 ☐ 2 ☐ 3+ medications
- ☐ treated for water retention or edema in the last 12 months
- ☐ other _____

Please continue to the next page to tell us about symptoms, investigations and treatments. ▶

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Applicant's name (please print) _____ **Date** MM/DD/YYYY

Diabetes

☐ **NO** ☐ **YES** – please check all that apply

- ☐ pre-diabetes
- ☐ diet-controlled diabetes
- ☐ type 1 diabetes (insulin)
- ☐ type 2 diabetes (oral medication)
- ☐ chronic kidney failure
- ☐ diabetic neuropathy
- ☐ skin infection (in last 30 days)
- ☐ lung infection (in last 30 days)
- ☐ diabetic retinopathy
- ☐ other _____

Blood Vessels

☐ **NO** ☐ **YES** – please check all that apply

- ☐ aneurysm
  - ➥ repaired? ☐ NO ☐ YES
  - ➥ location:
    - ☐ abdominal ☐ brain
    - ☐ thoracic ☐ heart
- ☐ atherosclerosis
- ☐ angina
- ☐ phlebitis (vein inflammation)
- ☐ peripheral vascular disease (PVD)
- ☐ deep vein thrombosis (DVT)
- ☐ thrombophlebitis
- ☐ varicose veins
  - ➥ surgery? ☐ NO ☐ YES
- ☐ other _____

Lung Condition

☐ **NO** ☐ **YES** – please check all that apply

- ☐ chronic obstructive pulmonary disease (COPD)
- ☐ emphysema
- ☐ asthma
  - ☐ no medication
  - ☐ prednisone
  - ☐ inhaler
- ☐ bronchitis
  - ☐ 3 or more episodes in last 24 months
- ☐ tuberculosis
- ☐ pulmonary fibrosis
- ☐ use of home oxygen
- ☐ lung transplant
- ☐ other _____

Heart

☐ **NO** ☐ **YES** – please check all that apply

- ☐ cardiomyopathy
- ☐ chest pain or angina
- ☐ prescribed and/or used any form of nitroglycerin (spray, patch, pill)
- ☐ heart attack
  - ➥ How many have you had?
    - ☐ 1 ☐ 2 ☐ 3+
- ☐ cardiac or heart surgery
- ☐ heart transplant
  - ➥ What type of surgery?
    - ☐ balloon angioplasty
    - ☐ stent angioplasty
    - ☐ coronary artery bypass graft
      - ➥ How many arteries were grafted?
        - ☐ 1 ☐ 2 ☐ 3 ☐ 4
- ☐ 3 or more bypass operations
- ☐ heart valve problem
  - ☐ heart valve surgery
  - ☐ balloon valvuloplasty
  - ☐ stent valvuloplasty
  - ☐ valve replacement
- ☐ irregular heart beat or rate (arrhythmia, bradycardia, tachycardia, atrial fibrillation, palpitations)
  - ☐ on medication
- ☐ pacemaker inserted
- ☐ external defibrillator
- ☐ internal defibrillator
- ☐ ablation
- ☐ heart murmur
- ☐ congestive heart failure
- ☐ coronary artery disease
- ☐ other _____

Stroke / TIA

☐ **NO** ☐ **YES** – please check all that apply

- ☐ stroke
  - ➥ How many have you had?
    - ☐ 1 ☐ 2 ☐ 3+
- ☐ require any assistance with activities of daily living
- ☐ transient ischemic attack (TIA) or mini-stroke
  - ➥ How many have you had?
    - ☐ 1 ☐ 2 ☐ 3+
- ☐ endarterectomy (surgery on your carotid arteries)
- ☐ prescribed blood thinner (for example Warfarin, Coumadin)
  - ☐ before stroke
  - ☐ after stroke
- ☐ other _____

Muscle / Skeletal

☐ **NO** ☐ **YES** – please check all that apply

- ☐ arthritis
- ☐ rheumatoid arthritis
- ☐ osteoporosis, osteopenia
- ☐ degenerative disc disease (DDD)
- ☐ fibromyalgia
- ☐ herniated disc, spinal stenosis
- ☐ sciatica
- ☐ scoliosis
- ☐ spondylosis
- ☐ other _____

Please continue to the next page to tell us about symptoms, investigations and treatments. ▶

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Applicant's name (please print) _____ **Date** MM/DD/YYYY

Stomach or bowel (intestine or colon) condition (including gallbladder, hernia, throat and liver)

☐ **NO** ☐ **YES** – please check all that apply

Gallbladder
- ☐ gallbladder attack
- ☐ gallstones
- ☐ gallbladder removed

Bowel/intestine or colon
- ☐ celiac disease
- ☐ inflammatory bowel disease (Crohn's disease, ulcerative colitis)
- ☐ diverticulosis
- ☐ diverticulitis
- ☐ undiagnosed intestinal or rectal bleeding (not including hemorrhoids)
- ☐ irritable bowel syndrome (IBS)

Stomach
- ☐ gastric bypass surgery
- ☐ GERD, acid reflux or heartburn
- ☐ gastritis
- ☐ h. pylori
- ☐ hernia
  - ➥ repaired? ☐ NO ☐ YES
- ☐ ulcer
  - ➥ repaired? ☐ NO ☐ YES

Liver
- ☐ liver disease
- ☐ hepatitis ☐ A ☐ B ☐ C
- ☐ cirrhosis of the liver
- ☐ liver transplant

Throat
- ☐ scleroderma, dysphagia, incoordination or achalasia

Other _____

Kidney or urinary condition

☐ **NO** ☐ **YES** – please check all that apply

- ☐ kidney failure
- ☐ kidney dialysis
- ☐ kidney transplant
- ☐ 2 or more urinary infections in last 12 months
- ☐ protein in urine
- ☐ kidney cysts
- ☐ kidney / bladder stones
  - ➥ How many times have you had stones? ☐ 1 ☐ 2+
- ☐ other _____

Cancer

☐ **NO** ☐ **YES** – please check all that apply

➥ Location:
- ☐ brain ☐ breast ☐ bone
- ☐ bowel, colon, intestine
- ☐ Hodgkin's lymphoma
- ☐ kidney ☐ leukemia
- ☐ liver ☐ lung
- ☐ ovarian / cervical
- ☐ prostate ☐ bladder
- ☐ skin ☐ stomach
- ☐ throat
- ☐ other_____
- ☐ cancer has spread to other organs of the body
- ☐ inoperable ☐ in remission
- ☐ eliminated
- ☐ under treatment
  - ☐ chemotherapy
  - ☐ radiation treatment
  - ☐ hormone replacement treatment
  - ☐ surgery
  - ☐ watchful waiting
  - ☐ treatment is pending
- ☐ treatment declined
- ☐ other _____

Uterine fibroids, ovarian cysts or prostate

☐ **NO** ☐ **YES** – please check all that apply

- ☐ uterine fibroid
  - ➥ surgery ☐ NO ☐ YES
- ☐ hysterectomy
- ☐ ovarian cyst
  - ➥ surgery ☐ NO ☐ YES
- ☐ benign prostatic hypertrophy (BPH)
  - ☐ on medication
  - ☐ surgery
  - ☐ other _____

Nervous system conditions

☐ **NO** ☐ **YES** – please check all that apply

- ☐ anxiety / emotional disorder
- ☐ Parkinson's disease
- ☐ Guillain-Barre syndrome
- ☐ epilepsy or seizures
- ☐ Alzheimer's disease
  - ☐ travelling alone ☐ NO ☐ YES
  - ☐ require any assistance with activities of daily living
- ☐ migraines
- ☐ other _____

Pregnancy

If you are female, are you currently pregnant?

☐ **NO** ☐ **YES**

If yes, what is your expected delivery date?

MM/DD/YYYY _____

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	MM/DD/YYYY
Applicant's name (please print)	**Date**

Please tell us about the history of ALL your medical conditions you checked on page 2 and 3. We need to know about your symptoms, any investigations, treatments and prescriptions you've had. Attach a separate sheet if necessary.

Medical condition	Medication	Date prescribed	Last dosage change	Symptoms/investigation/treatment and date
		MM/DD/YYYY	MM/DD/YYYY	
		MM/DD/YYYY	MM/DD/YYYY	
		MM/DD/YYYY	MM/DD/YYYY	
		MM/DD/YYYY	MM/DD/YYYY	
		MM/DD/YYYY	MM/DD/YYYY	

Declaration

You declare that: The information you've provided in this questionnaire is truthful, complete and accurate.

You understand that:

- This questionnaire and the answers you provided are part of a contract provided through AZGA Service Canada Inc. o/a Allianz Global Assistance.
- If your medical status or any of your answers changes between the date you complete this questionnaire and your departure date or the effective date of any extension, you must contact Allianz Global Assistance prior to leaving on your trip to fully understand how your change in health affects the underwriting decision. Failure to do so may limit the amount of your claim payment or result in your claim being denied.
- The underwriting decision applies regardless of the sales medium and/or channel through which you purchase insurance. If a policy is issued to you that does not include this underwriting decision, it will be considered null and void, any premiums paid will be refunded and no claims will be payable.
- Allianz Global Assistance will collect, use and/or disclose your personal information only to provide you with the insurance products and services you've requested, for other uses authorized by you, or as required by law.

You acknowledge that:

If you misrepresent your medical status in this questionnaire, or if you don't disclose material information about your medical status, or if any of your answers are found to be incorrect or untrue, your coverage will be null and void, your claims won't be paid and your premium will be refunded, even if the material non-disclosure or inaccuracy is not related to the claim reported, and you will be solely responsible for all expenses related to your claim.

This coverage is subject to exclusions, terms, conditions and limitations that may limit or exclude an amount payable.

Authorization

You authorize: Any organization or person that has records or knowledge of your health to give any and all information[1] regarding your health, medical history and treatment to Allianz Global Assistance or its authorized representatives.

You understand and agree that:

- If you refuse or withdraw this authorization your application will be denied.
- A copy of this authorization and declaration is as valid as the original.

I HAVE READ AND UNDERSTOOD THE IMPORTANT INFORMATION IN THE STATEMENT ABOVE ☐ **NO** ☐ **YES**

You must sign and date this questionnaire or it will be returned to you.

Applicant's name (please print)	Signature
MM/DD/YYYY	MM/DD/YYYY
Date	Signature date

[1] IMPORTANT: 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.

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