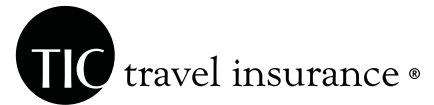


Detailed medical questionnaire



Underwritten by Co-operators Life Insurance Company.

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

TIC Travel Insurance Coordinators Ltd.

Underwriting Department
250 Yonge Street, Suite 2100
Toronto, Ontario M5B 2L7

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

Email: directuw@travelinsurance.ca

Eligibility

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

Coverage is NOT AVAILABLE to any individual who does not meet eligibility or who:

- a) has been diagnosed with a terminal illness;
- b) has been diagnosed with or has had an episode of congestive heart failure;
- c) has Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV);
- d) has Alzheimer's disease or any other type of dementia;

- e) has received any type of treatment for pancreatic cancer, liver cancer or any type of cancer that has metastasized;
- f) has been prescribed or used home oxygen treatment in the last 12 months;
- g) has had a major organ transplant (heart, kidney, liver, lung);
- h) has received kidney dialysis treatment in the last 12 months.

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

Do you confirm that you are eligible to apply?

NO YES

Applicant Information

Last name: _____ First name: _____ Date of birth: _____
(please print) (mm/dd/yyyy)

Your mailing address Street: _____ Apt #: _____

City: _____ Province: _____ Postal code: _____

Phone: _____ Fax: _____ E-mail: _____

Destination: _____ Date of departure: _____ Date of return: _____
(mm/dd/yyyy) (mm/dd/yyyy)

Single-trip Multi-trip Visitors to Canada Top-Up or Extension

Company name: _____ Policy number: _____

Agent/Broker Information

Who should we contact? Applicant Agent/Broker

Agency/Broker Name: _____ Agent Code: _____ Phone: _____

Please send correspondence by: Fax: E-mail :

Attention: _____

Applicant's name (please print)

Date (mm/dd/yyyy)

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 that applies to you. If more than one condition applies, check the box for **every** condition.

Heart and cardiovascular

- no**
- yes** – please check all that apply

- arrhythmia, fibrillation, palpitations or any irregular heart rate
- heart murmur

- chest pain or angina
- arteriosclerosis
- coronary artery disease
- congestive heart failure
- by-pass surgery
- use pacemaker or defibrillator
- valve replacement or abnormality

- heart attack, myocardial infarction
- congenital heart defect
- prescribed and /or used any form of nitroglycerin
- angioplasty or stent
- other: _____

Stroke, cerebrovascular and neurological

- no**
- yes** – please check all that apply

- cerebrovascular accident (CVA), stroke
- transient ischemic attack (TIA) or mini-stroke

- ongoing therapy
- paralysis _____
- use of cane, walker, wheelchair or other mobility device
- hydrocephalus
- parkinson's disease
- seizures

- migraine
- epilepsy
- aneurysm
- Alzheimer's disease or dementia
- mental or nervous disorder, or anxiety
- neurological disorder _____
- other: _____

Lung and respiratory

- no**
- yes** – please check all that apply

- chronic obstructive pulmonary disease (COPD)
- asthma

- chronic bronchitis
- bronchial asthma
- pulmonary embolism
- sarcoidosis of lung
- sleep apnea
- emphysema
- asbestosis

- tuberculosis
- pulmonary fibrosis
- use of home oxygen
- use of prednisone
- use of cortisone
- other: _____

Internal Conditions

- no**
- yes** – please check all that apply

- liver disease
- kidney disorder (including stones)
- kidney failure
- spleen or pancreatic disorder
- gallbladder disorder
- prostate disorder

- urinary disorder
- ovarian or uterine disorder
- artery or vein disorder
- peripheral vascular disease
- other: _____

Gastrointestinal conditions

- no**
- yes** – please check all that apply

- esophagus disorder
- stomach disorder

- bowel, colon or intestine disorder
- ulcer
- diverticulitis
- diverticulosis
- hernia (specify type) _____

- GERD, heartburn, acid reflux
- irritable bowel syndrome (IBS)
- ulcerative colitis
- Crohn's disease
- other: _____

Cancer

- no**
- yes** – please check all that apply

Is your cancer eliminated?

- no**
- yes**

- Location of cancer _____
- Date of last treatment _____
- radiation treatment
- chemotherapy
- brachytherapy
- hormone therapy
- surgery

- metastasis
- leukemia (specify type): _____
- in remission
- no treatment required
- treatment declined
- other: _____

Other Conditions

- no**
- yes** – please check all that apply

Aneurysm: repaired? **no** **yes**

- Location: abdominal
 aortic (AAA)
 brain
 heart

- diabetes controlled by diet
- diabetes – oral medication
- diabetes – insulin
- blood disorder
- idiopathic thrombocytopenic purpura
- hemochromatosis
- anemia
- multiple sclerosis
- cystic fibrosis
- Lou Gehrig's disease (ALS)
- Acquired Immune Deficiency (AIDS) or Human Immunodeficiency Virus (HIV)

- scleroderma
- sarcoidosis any location
- high blood pressure
- high cholesterol
- systematic lupus erythematosus
- arthritis
- osteoporosis, osteopenia
- muscle or skeletal disorders
- use of prednisone, cortisone
- use of walker, cane or mobility device
- other: _____

Applicant's name (please print)

Date (mm/dd/yyyy)

Medical Information

Height: [] ft [] in [] cm Weight: [] lbs [] kg Have you smoked in the last 24 months? [] No [] Yes

Family doctor name: Phone number:

Name of last physician or medical clinic you visited: Phone number: Date you visited: (mm/dd/yyyy)

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

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:

Do you need assistance with activities of daily living? [] No [] Yes (eating, bathing, using the toilet, changing positions (including getting in and out of a bed or chari) and dressing)

Please provide details:

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

Table with 5 columns: Medical condition, Medication, Date prescribed, Date of last dosage change, Symptoms/investigation/treatment and date

Have you EVER been hospitalized or had surgery recommended or scheduled? [] No [] Yes

Please provide details:

Table with 3 columns: Medical condition, Treatment, Date (mm/dd/yyyy)

In the last five years, have you been declined life, health or travel insurance or refused renewal of coverage? [] No [] Yes

Please provide details:

Declaration and authorization

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 TIC Travel Insurance Coordinators Ltd.
- If your medical status or any of your answers changes between the date you complete this questionnaire and your departure date or top-up/extension effective date, you must notify TIC Travel Insurance Coordinators Ltd. immediately or your coverage will be null and void.
- 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.

- TIC 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 regarding your health, medical history and treatment to TIC Travel Insurance Coordinators Ltd. 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

Applicant's name (please print)

Date (mm/dd/yyyy)

Signature

Date (mm/dd/yyyy)

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