

Underwritten by: Co-operators Life Insurance Company
Assistance Services by: SelectCare Worldwide
Managed by: The Destination: Travel Group Inc.

**Questions? Contact your Broker or
 call us at 1-800-337-3532**

2010/2011 APPLICATION FOR INSURANCE

Part 1 – Eligibility Requirements:

Medical Questionnaire:

If you are unsure of your eligibility based on your medical history, please consult with your physician.

You must complete the following eligibility requirements if you are age 50 or over on your date of application.

If you are under age 55, call your broker or Destination: Travel at the above number to inquire about our

Destination: Travel Leisure Plan which may better meet your travel needs.

First Name First Name

Applicant 1 Applicant 2

Table 1			
	high blood pressure (hypertension)	diabetes (excluding diet controlled diabetes)	stroke (CVA)
	heart attack (myocardial infarction)	kidney disorder	transient ischemic attack (TIA)
	coronary artery disease	a liver disorder	peripheral vascular disease
	angina	pancreatitis	blood clot(s)
	atrial fibrillation	chronic obstructive pulmonary disease (COPD)	diverticulitis/diverticulosis
	irregular heart beat or rhythm	asthma	Crohn's disease
	heart valvular disease	chronic bronchitis	ulcerative colitis
	any other heart condition	any other lung disorder	any other bowel disorder

1. Have you been hospitalized for 24 hours or more during the 12 months prior to your departure date for any of the following medical conditions: Heart condition, lung condition, diabetes (excluding diet controlled), stroke (CVA) or transient ischemic attack (TIA).	YES	NO	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. In the 12 months prior to your departure date, have you been diagnosed with or treated for 4 or more of the conditions listed above in Table One.	YES	NO	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Within the 12 months prior to your departure date, have you:	YES	NO	YES	NO
(i) been prescribed 4 or more separate and distinct prescription medications (excluding Aspirin) for the <i>treatment</i> of any one of the conditions listed above in Table 1 ;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(ii) been prescribed 6 or more separate and distinct prescription medications (excluding Aspirin) in total for all of the medical conditions listed above in Table 1 ;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(iii) been recommended for heart, lung or gastrointestinal surgery, which has been postponed, delayed or refused by you or your physician(s);	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(iv) had an aneurysm that has not been surgically repaired;.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(v) had a lung condition which required the daily use of Prednisone for more than 180 consecutive days ;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(vi) been using Lasix/Furosemide daily for more than 30 consecutive days ;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(vii) been diagnosed with or received <i>treatment</i> for congestive heart failure (CHF)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Within the 24 months prior to your departure date, have you:	YES	NO	YES	NO
(i) been diagnosed with or <i>treated</i> for kidney or renal failure, required kidney dialysis, or had your physician suggest/recommend that you undergo kidney dialysis;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(ii) been diagnosed with a terminal illness;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(iii) been diagnosed with or <i>treated</i> for emphysema, cirrhosis of the liver or had 3 or more gastrointestinal bleeds;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(iv) been prescribed home oxygen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you:	YES	NO	YES	NO
(i) had your most recent coronary by-pass or coronary angioplasty surgery (if any) more than 12 years prior to your departure date;.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(ii) within the 5 years prior to your departure date, had 2 or more of the following procedures: coronary by-pass, coronary angioplasty, stenting, pacemaker insertion, or valve replacement(s) (2 procedures performed during the same surgery count as 1);	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(iii) within the last 6 months, been told by a physician that you should postpone or not travel;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(iv) had an organ transplant (heart, lung, liver, kidney) or a bone marrow transplant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the questions 1 through 5 above, you are not eligible to purchase this insurance. Other coverage options are available. Please consult with your insurance broker or agent or contact us at 1-800-337-3532.

If you answered NO to questions in 1 through 5 above, please continue to Part 2 and Part 3 of this application.

IMPORTANT: If your health status changes prior to your policy effective date which makes you no longer eligible for this policy, you must notify Destination: Travel Health Plans immediately and upon submission of proof of ineligibility, will receive a full refund.

I have read the above eligibility questions. I understand them, and declare that all answers are correct. I acknowledge that any policy and coverage provided to me on the basis of the answers given will be deemed null and void if any answer is not correct.

X

 APPLICANT 1 SIGNATURE

X

 APPLICANT 2 SIGNATURE

Applicant 1 <input type="checkbox"/> Male <input type="checkbox"/> Female	Applicant 2 <input type="checkbox"/> Male <input type="checkbox"/> Female	
Last Name	Last Name	
First Name	First Name	
Date of Birth DD MM YY Age at Application _____	Date of Birth DD MM YY Age at Application _____	
Government Health Plan #	Government Health Plan #	
Address		Apt.
City	Prov.	Postal Code
Emergency Contact Name		Phone ()
		Phone ()

Part 3 – Plan Classification - Only complete Part 3 if you are eligible for this insurance as stated in Part 1

Destination: Travel Health Plans offers 4 plan classifications. If you are unsure which plan classification applies based on your medical history, please discuss with your physician. Italicized words are defined in Part 6 of this application.

Table 2		Table 3	
coronary artery disease	diabetes (excluding diet controlled)	pancreatitis	diverticulitis/diverticulosis
angina	chronic obstructive pulmonary disease (COPD)	Alzheimer's disease or dementia	Crohn's disease
atrial fibrillation	chronic bronchitis	a chronic liver disorder	ulcerative colitis
irregular heart beat or rhythm	any other chronic lung disorder (excluding asthma)	peripheral vascular disease	any other chronic bowel disorder
heart valvular disease	stroke (CVA)	blood clot(s)	High blood pressure
any other heart condition	transient ischemic attack (TIA)		

Please read each classification carefully then mark the box next to the plan classification for which you qualify.

Please Select Only One (1) Classification

	Applicant 1	Applicant 2
<p>PREMIER – I understand that in order to <u>qualify for this plan</u>:</p> <p>a) I must not during the 5 years prior to my departure date, been diagnosed with or <i>treated</i> for any of the medical conditions listed in Table 2 or Table 3 <u>excluding high blood pressure (hypertension) treated with 1 medication only</u>;</p> <p>b) I must have undergone a medical check-up with my physician within 18 months prior to my departure date.</p> <p>The Premier classification requires a <i>stability</i> period of 90 days.</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>ULTRA PREFERRED – I understand that in order to <u>qualify for this plan</u>:</p> <p>a) I must not during the 12 months prior to my departure date, been diagnosed with or <i>treated</i> for any of the medical conditions listed above in Table 2;</p> <p>b) I must not in the 12 months prior to my departure date, been diagnosed with or <i>treated</i> for 3 or more medical conditions listed above in Table 3;</p> <p>c) I must not at my departure date, been prescribed 3 or more high blood pressure medications.</p> <p>The Ultra Preferred classification requires a <i>stability</i> period of 12 months (90 days for high blood pressure).</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>SUPER PREFERRED – I understand that in order to <u>qualify for this plan</u>:</p> <p>a) I must not in the 12 months prior to my departure date, been diagnosed with or <i>treated</i> for 2 or more of the medical conditions listed above in Table 2;</p> <p>b) I must not in the 12 months prior to my departure date, been diagnosed with or <i>treated</i> for 3 or more of the medical conditions listed above in Table 2 and Table 3.</p> <p>The Super Preferred classification requires a <i>stability</i> period of 12 months (90 days for high blood pressure).</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>ELITE PREFERRED – I understand that in order to <u>qualify for this plan</u>:</p> <p>a) I must not in the 12 months prior to my departure date, been diagnosed with or <i>treated</i> for 3 or more of the medical conditions listed above in Table 2;</p> <p>b) I must not in the 12 months prior to my departure date, been diagnosed with or <i>treated</i> for 4 or more of the medical conditions listed above in Table 2 and Table 3.</p> <p>The Elite Preferred classification requires a <i>stability</i> period of 12 months (90 days for high blood pressure).</p>	<input type="checkbox"/>	<input type="checkbox"/>

I have read the above plan classifications. I understand them, and I acknowledge that any policy and coverage provided to me on the basis of these plan classifications will be deemed null and void if I do not meet the qualifications of the plan classification I have selected.

I further understand that if I qualify for one of the above plan classifications, I will be covered for any medical condition(s) that have been *stable* at all times during the *stability* period described in your chosen plan qualification. The *stability* period applies prior to: (i) each date I depart my province/territory of residence for the Annual/Multi-Trip Plan coverage; and/or (ii) the policy effective date for the Single Trip Plan and/or Top-Up Plan coverage. All *minor conditions* that meet the definition in Part 6 are considered *stable*.

X	X
Applicant 1 Signature	Applicant 2 Signature

Please base your rates on the plan classification you selected in Part 3 of Page 2

Single Trip Coverage: (Count both the Departure and Return Dates when determining the # of Travel Days)

<p>Applicant 1</p> <p>Departure Date (Policy Effective Date) DD MM YY</p> <p>Return Date (Policy Expiry Date) DD MM YY</p> <p>Daily Rate X # of Days = \$ _____ A1</p>	<p>Applicant 2</p> <p>Departure Date (Policy Effective Date) DD MM YY</p> <p>Return Date (Policy Expiry Date) DD MM YY</p> <p>Daily Rate X # of Days = \$ _____ A2</p>
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Annual / Multi-Trip Coverage:

Covers the first 8, 15, 30 or 60 days of any trip taken during the 365-day period from your policy effective date (age restrictions apply).

<p>Applicant 1</p> <p><input type="checkbox"/> 8 days <input type="checkbox"/> 15 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days</p> <p>Policy Effective Date DD MM YY</p> <p>Annual / Multi-Trip Premium = \$ _____ B1</p>	<p>Applicant 2</p> <p><input type="checkbox"/> 8 days <input type="checkbox"/> 15 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days</p> <p>Policy Effective Date DD MM YY</p> <p>Annual / Multi-Trip Premium = \$ _____ B2</p>
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Top Up Coverage:

(Must be purchased BEFORE Departure. Extends other coverage or your **Destination: Travel Annual/Multi-Trip Plan.**)

<p>Applicant 1</p> <p>(Please ensure that the top-up policy effective date is the day after your other coverage expires.)</p> <p>Departure Date DD MM YY</p> <p>Top-up Policy Effective Date DD MM YY</p> <p>Return Date (Policy Expiry Date) DD MM YY</p> <p>Top-Up Trip Length: _____</p> <p>Insurance Company Name: _____</p> <p># of days of Existing Coverage: _____</p> <p>Policy and/or Certificate number: _____</p>	<p>Applicant 2</p> <p>Departure Date DD MM YY</p> <p>Top-up Policy Effective Date DD MM YY</p> <p>Return Date (Policy Expiry Date) DD MM YY</p> <p>Top-Up Trip Length: _____</p> <p>Insurance Company Name: _____</p> <p># of days of Existing Coverage: _____</p> <p>Policy and/or Certificate number: _____</p>
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Premium for Top-Up Coverage

<p>Daily Rate X # of Days = \$ _____ C1</p>	<p>Daily Rate X # of Days = \$ _____ C2</p>
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Part 5 – Premium Calculation

Minimum Premium \$25.00 per Applicant

<p>Applicant 1</p> <p>Premium Subtotal A1 + B1 + C1 = \$ _____ P1</p> <p>Have you used Tobacco products within 12 months prior to your departure date? <input type="checkbox"/> No <input type="checkbox"/> Yes + 10%</p> <p>If you answer "Yes" to the tobacco usage question above Multiply P1 by 1.10 = \$ _____ P3</p> <p>If you apply with a companion you are eligible for a 5% Discount.</p> <p>To apply the companion discount, please Multiply P3 by 0.95 = \$ _____ P5</p>	<p>Applicant 2</p> <p>Premium Subtotal A2 + B2 + C2 = \$ _____ P2</p> <p>Have you used Tobacco products within 12 months prior to your departure date? <input type="checkbox"/> No <input type="checkbox"/> Yes + 10%</p> <p>If you answer "Yes" to the tobacco usage question above Multiply P2 by 1.10 = \$ _____ P4</p> <p>If you apply with a companion you are eligible for a 5% Discount.</p> <p>To apply the companion discount, please Multiply P4 by 0.95 = \$ _____ P6</p>
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All coverage is subject to a \$250 US deductible per incident of claim unless you choose otherwise.

<p>To eliminate this deductible check the box below:</p> <p>\$0 – No Deductible Multiply P5 by 1.10 <input type="checkbox"/></p> <p>To increase your deductible check the corresponding box below:</p> <p>\$500 US Multiply P5 by 0.95 <input type="checkbox"/></p> <p>\$1,000 US Multiply P5 by 0.90 <input type="checkbox"/></p> <p>\$5,000 US Multiply P5 by 0.70 <input type="checkbox"/></p> <p>\$10,000 US Multiply P5 by 0.55 <input type="checkbox"/></p> <p>Subtotal after adjustment for deductible = \$ _____ P7</p>	<p>To eliminate this deductible check the box below:</p> <p>\$0 – No Deductible Multiply P6 by 1.10 <input type="checkbox"/></p> <p>To increase your deductible check the corresponding box below:</p> <p>\$500 US Multiply P6 by 0.95 <input type="checkbox"/></p> <p>\$1,000 US Multiply P6 by 0.90 <input type="checkbox"/></p> <p>\$5,000 US Multiply P6 by 0.70 <input type="checkbox"/></p> <p>\$10,000 US Multiply P6 by 0.55 <input type="checkbox"/></p> <p>Subtotal after adjustment for deductible = \$ _____ P8</p>
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Total Premium Due P7 + P8 = \$ _____ P9

Minimum Premium \$25.00 per Applicant

Stable or stability: Means that my medical condition(s) is/are not worsening and there has been no alteration in any medication for the condition or in its usage or in its dosage, nor any alteration in *treatment* prescribed or recommended by a physician. The following are not considered alterations or changes in medications: the change from a brand named medication to a generic brand medication provided that the usage or dosage has not changed; a new medication prescribed solely as a result of a drug manufacturer's discontinuance of the original medication taken; the dosage changes of the regulatory medications insulin and coumadin; the dosage changes of thyroid and/or hormone medications; the decrease or elimination of a medication dosage by a physician, provided that it has changed more than 90 days prior to your policy effective date and has not had any effect on the *stability* of your medical condition for the 90 days prior to your departure/effective date.

Treatment, treat or treated: Means a medical, therapeutic or diagnostic procedure prescribed, performed or recommended by a physician, including but not limited to prescription medication, surgery or investigative testing that results in a diagnosis of a specific medical condition. Does not include *minor conditions*.

Minor Condition: Means an ailment which does not require any follow up consultation to any medical provider beyond one single assessment and includes the use of prescription medication for a maximum period of ten days, and which has not reoccurred in the six month period following the initial manifestation.

Part 7 - Payment Options

- Cheque Please make cheque payable to Destination: Travel Health Plans or your Broker
 Visa MasterCard

Cardholder's Name _____

Cardholder's Number _____ Expiry Date _____

Signature of Cardholder _____ MM / YY
(Only if different from applicant(s)) _____

Part 8 – Declaration and Authorization

- I declare that on my departure date(s), I will meet the eligibility and plan classification requirements. Where I was unsure of my medical condition(s), I consulted with my physician and I understand that only my physician or I can establish my eligibility for this policy. I understand that in applying for coverage under this policy it is my responsibility to be aware of all my medical conditions. I understand that no statement made by me or any agent prior to or at the time of my application for insurance will be considered valid unless such statement has been documented and submitted in writing and accepted by Destination: Travel Health Plans prior to the completion of this application. I understand the eligibility and plan classification requirements are material to the risk and form part of the application/policy and in consideration for the insurance for which I am applying.
- I acknowledge that any misrepresentations and non-disclosure of my medical status will result in non-payment of my claim and render my coverage null and void resulting in the refund of my premium.
- If I am found to be not eligible for this insurance, SelectCare Worldwide, on behalf of Co-operators Life Insurance Company has the right to collect from me any monies paid out on my behalf.
- I understand that the insurance applied for will not become effective unless Destination: Travel Health Plans / Co-operators Life Insurance Company accepts this application and receives the full premium and a signed and dated copy of the application. Destination: Travel Health Plans / Co-operators Life Insurance Company has the right to decline any application without explanation. In the event that this application is not accepted, I will receive a full refund. I understand that certain terms, conditions, limitations and exclusions will apply and that only treatment for medical emergencies will be covered under this insurance.
- Medical Authorization in Case of Claim – I understand that Co-operators Life Insurance Company and SelectCare Worldwide may investigate my claim. By signing this application, I hereby direct and authorize any physician, health care practitioner, hospital or other 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 furnish to Destination: Travel Health Plans / Co-operators Life Insurance Company and to SelectCare Worldwide any or all information with respect to any illness, injury, medical history, consultations, medicines or *treatment* and copies of all hospital and/or medical records for the purpose of investigating my claim. Your personal information is also collected for the purpose of providing insurance services, claims analysis and payments. For Privacy information please see www.cooperatorstravelinsurance.ca.
- I hereby direct and authorize any other insurance plan under which I am covered for benefits to disclose personal information as may be necessary or to make payment in respect of my claim to Co-operators Life Insurance Company and SelectCare Worldwide directly.
- This authorization remains valid until any claim pending or disputed under a policy issued as a result of this application is settled unless an applicable law specifies a shorter period, in which case it would expire within the period applicable under that law.
- I/We the undersigned consent to Co-operators Life Insurance Company / SelectCare Worldwide providing Destination: Travel Health Plans with any and all data related to claims information.
- A photocopy, electronic copy or fax of this authorization will be treated in the same manner as the original.
- If I/we am/are paying for this insurance by credit card, I/we authorize this transaction.

Each Applicant Must Sign Below

Signature Applicant 1 _____

Signature Applicant 2 _____

Date of Application _____
DD / MM / YY

Broker Use Only

Broker ID _____

Broker Name _____