

MEDICAL QUESTIONNAIRE AND APPLICATION FORM

Instructions

Medical questions help us to determine your eligibility and premium rate if you are age 55 or over.

1. If you are under the age of 55, proceed to Part C to complete the application.
2. If you are applying for the Quick Trip Plan, you must be 55 to 74 years of age and travelling for 17 days or less. You do not need to complete the Medical Questionnaire in Part A. If you are purchasing the Quick Trip Plan, you qualify for Rate Category D in which case, you will not be covered for any expenses relating to:
 - a *pre-existing condition* for which you have taken, received or been prescribed medication or *treatment* in the three (3) months before your effective date; and/or
 - your heart condition if, in the three (3) months before your effective date, you have taken, received or been prescribed medication or *treatment* or you have taken any form of nitroglycerine for the relief of angina pain; and/or
 - your lung condition if, in the three (3) months before your effective date you have taken, received or been prescribed medication or *treatment* or you required *treatment* with oxygen or prednisone for your lung condition.

Complete Part C of this application.

3. All other applicants must complete the medical questionnaire in Part A and the Applicant's Declaration in Part B to apply for this insurance. If you are uncertain of your answers to any medical questions, please consult your doctor before completing this medical questionnaire.
4. All applications must be completed before the effective date of insurance.

Plan Information

Emergency Medical Single Trip Plan – Provides coverage for a single trip while travelling outside your province or territory of residence.

Emergency Medical Multi-Trip Plan – Provides coverage for any number of trips up to the option you selected (4, 10, 18 or 30 days). Trips must be separated by a return to your province or territory of residence or Canada. The Multi-Trip Plans offer unlimited travel within Canada (excluding your province or territory of residence).

Travel Canada Emergency Medical Plan – Provides coverage for a single trip while travelling within Canada and outside your province or territory of residence.

Quick Trip Plan – Provides coverage for a single trip while travelling outside your province or territory of residence, up to 17 days, if you are between ages 55 and 74.

Quick Trip Canada Plan – Provides coverage for a single trip while travelling within Canada and outside your province or territory of residence, up to 17 days, if you are between ages 55 and 74.

Definitions

Italicized words have a specific meaning. Please refer to the following definitions when completing the Medical Questionnaire.

Change in medication means the medication dosage or frequency has been reduced, increased, or stopped and/or new medication(s) has/have been prescribed.

Exceptions: the routine adjustment of Coumadin, warfarin or insulin, (as long as they are not newly prescribed or stopped) and there has been no change in your *medical condition*; and a change from a brand name medication to a generic brand medication of the same dosage.

Hospital means a facility that is licensed as a hospital where in-patients receive medical care and diagnostic and surgical services under the supervision of a staff of physicians with 24-hour care by registered nurses. A clinic, an extended or palliative care facility, a rehabilitation establishment, an addiction centre, a convalescent, rest or nursing home, home for the aged or health spa is not a *hospital*.

Medical condition means injury, illness or disease, complication of pregnancy within the first thirty-one (31) weeks of pregnancy, or a mental or emotional disorder that requires admission to a *hospital*, or acute psychosis.

Medical emergency means a sudden unforeseen occurrence of symptoms, injury, illness, or disease which requires immediate *treatment*.

Pre-existing condition means a *medical condition* that existed before your effective date.

Stable – a *medical condition* is *stable* if all of the following apply during the specified stability period:

- you have not had any new symptom(s); and
- existing symptom(s) have not become more frequent or severe; and
- your physician has not determined that your *medical condition* has become worse; and
- no test findings have shown that your *medical condition* may be getting worse; and
- you have not received, been prescribed, taken or had a *physician* recommend any new medication, any *change in medication*; and
- you have not received, been prescribed or had a physician recommend any new *treatment* or any change in *treatment*; and
- you have not been hospitalized or referred to a specialty clinic or specialist; and
- your *physician* has not advised you to see a specialist or to have further tests, and you have not undergone testing for which you have not yet received the results.

Treatment means a medical, therapeutic or diagnostic procedure prescribed, performed or recommended by a licensed medical practitioner, including but not limited to prescribed medication, investigative testing and surgery related to any illness, injury or symptom.

Part A • Medical Questionnaire

NAME OF APPLICANTS (Last Name, First Name)

Applicant 1	Applicant 2
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Step 1 • ELIGIBILITY	Applicant 1	Applicant 2
1. Have you been advised by a physician not to travel at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you require kidney dialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever had a bone marrow or organ transplant (excluding corneal transplant)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you had a heart bypass, angioplasty or heart valve surgery more than ten (10) years ago?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the last five (5) years , have you been diagnosed with and/or had <i>treatment</i> for metastatic cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. In the last six (6) months , have you received chemotherapy and/or radiotherapy and/or other <i>treatment</i> , other than routine follow-up, for cancer (except basal cell and squamous cell skin cancer, and breast cancer treated only with hormonal therapy)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. In the last twelve (12) months , have you been prescribed or taken prednisone or oxygen or been hospitalized (as an in-patient or seen in the emergency department) for a lung condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. In the last two (2) years , have you: a) been prescribed or taken Lasix or furosemide for any reason? b) had congestive heart failure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. In the last twelve (12) months , have you been hospitalized (as an in-patient or seen in the emergency department) for a heart condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. In the last four (4) months , have you been prescribed or taken six (6) or more prescription medications? Do not count the following medications: hormone replacement therapy (thyroid or menopausal); drugs used for osteoporosis, or traveller's diarrhea; or any form of immunization. Do not count topical medications that go in your nose, ears or eyes or on your scalp or skin except : any form of nitroglycerine or any drug(s) for angina.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. In the last three (3) years , have you been diagnosed with and/or had <i>treatment</i> for and/or been hospitalized (as an in-patient or seen in the emergency department) and/or been prescribed or taken medication for any two (2) of the following? (if you only have one (1) of the following conditions, answer NO) <ul style="list-style-type: none"> ■ Heart condition ■ Lung condition (medication includes any puffer(s)/inhaler(s), except a single unrepeated prescription medication used for a single episode) ■ Diabetes (treated with medication and/or insulin) ■ Stroke/CVA (cerebrovascular accident) or mini-stroke/TIA (transient ischemic attack) (including use of aspirin/Entrophen for this condition) ■ Narrowed or blocked artery in the legs (also called Peripheral Vascular Disease) ■ Alzheimer's disease, or any other form of dementia 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

ELIGIBILITY REQUIREMENT: If you must answer "YES" to ANY of the preceding questions, you are **not eligible** to purchase this insurance. **DO NOT** complete this questionnaire. Please contact your agent/broker if you wish to obtain a quote for our Individual Medical Underwriting plan. Continue to Step 2 if you are eligible to purchase this insurance.

Step 2 • FIND YOUR RATE CATEGORY	Applicant 1	Applicant 2
RATE QUALIFICATION • Part 1		
1. In the last five (5) years , have you been diagnosed with and/or had <i>treatment</i> and/or been hospitalized (as an in-patient or seen in the emergency department) and/or been prescribed or taken medication for any of the following? <ul style="list-style-type: none"> ■ Heart condition ■ Stroke/CVA (cerebrovascular accident) or mini-stroke/TIA (transient ischemic attack) (including use of aspirin/Entrophen for this condition) ■ Aneurysm ■ Narrowed or blocked artery in the legs (also called Peripheral Vascular Disease) ■ Diabetes (if treated with medication and/or insulin) ■ Lung condition (medication includes any puffer(s)/inhaler(s), except a single unrepeated prescription medication used for a single episode) ■ Cirrhosis of the liver ■ Alzheimer's disease, or any other form of dementia, or Parkinson's disease 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the last five (5) years , have you smoked or used any tobacco products and been prescribed or used any puffer(s)/inhaler(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the last six (6) months , have you received advice or <i>treatment</i> for a <i>medical emergency</i> more than once in the emergency room of a <i>hospital</i> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the last three (3) months , have you been prescribed or taken a total of three (3) or more medications for high blood pressure (hypertension) and/or a heart condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered "YES" to ANY of the questions in Step 2 • Part 1, you qualify for Rate Category C.

If you answered "NO" to ALL of the questions in Step 2 • Part 1, you must answer the question in Step 2 • Part 2.

RATE QUALIFICATION • Part 2	Applicant 1	Applicant 2
1. In the last two (2) years , have you been diagnosed with and/or received <i>treatment</i> for and/or been hospitalized (as an in-patient or seen in the emergency department) and/or been prescribed or taken prescription medication for any of the following conditions? <ul style="list-style-type: none"> ■ Bowel obstruction or surgery ■ Diverticular disorder requiring prescription medication or surgery ■ Gastrointestinal bleeding ■ Bleeding or perforated ulcer(s) ■ Chronic bowel disorder ■ Liver disorder ■ Pancreatic disorder ■ Kidney disorder (including stones) ■ Gallbladder disorder (including stones; if gallbladder has been removed answer NO) 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered "YES" to **two (2) or more** conditions listed in Step 2 • Part 2, you qualify for Rate Category C.

If you answered "YES" to **one (1)** condition listed in Step 2 • Part 2, you qualify for Rate Category B.

If you answered "NO" to ALL of the conditions listed in Step 2 • Part 2, you must answer the questions in Step 2 • Part 3.

RATE QUALIFICATION • Part 3		Applicant 1	Applicant 2
1. In the last two (2) years , have you been diagnosed with, and/or been hospitalized (as an in-patient or seen in the emergency department), and/or received <i>treatment</i> , and/or been prescribed medication by a Hematologist or an Internist for a blood disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the last twelve (12) months , have you been prescribed or used a puffer/inhaler?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the last twelve (12) months , have you been diagnosed with or received <i>treatment</i> for cancer, other than routine follow-up (except basal cell and squamous cell skin cancer, and breast cancer treated only with hormonal therapy)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you over 70, and have you had a fall for which you sought medical attention in the last six (6) months ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered "YES" to ANY of the questions in Step 2 • Part 3, you qualify for Rate Category B.

If you answered "NO" to ALL of the questions in Step 2 • Part 3, you must answer the question in Step 2 • Part 4.

RATE QUALIFICATION • Part 4		Applicant 1	Applicant 2
1. In the last two (2) years , have you smoked cigarettes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered "YES" to the question in Step 2 • Part 4, you qualify for Rate Category A.

If you answered "NO" to the question in Step 2 • Part 4, you qualify for Rate Category A+.

IMPORTANT: The rate category you qualify for determines the *pre-existing condition* exclusion that applies to your coverage. The *pre-existing condition* exclusions are detailed below.

RATE CATEGORY

I am 55 years of age or older and based on my answers above, I qualify for the following rate category:

Applicant 1: A+ A B C **Applicant 2:** A+ A B C

Pre-existing Condition Exclusion

The *pre-existing condition* exclusion which applies to you depends on your Rate Category as determined by the answers to the medical questions in Part A. All applicants 54 years of age or less automatically qualify for Rate Category A.

Rate Categories A+ and A. We will not pay any expenses relating to:

- a *pre-existing condition* that is not *stable* in the **three (3) months** before your effective date; and/or,
- your heart condition if, in the **three (3) months** before your effective date, it has not been *stable* or you have taken any form of nitroglycerine for the relief of angina pain; and/or,
- your lung condition if, in the **three (3) months** before your effective date, it has not been *stable* or you required *treatment* with oxygen or prednisone for your lung condition.

Rate Category B. We will not pay any expenses relating to:

- a *pre-existing condition* that is not *stable* in the **six (6) months** before your effective date; and/or,
- your heart condition if, in the **six (6) months** before your effective date, it has not been *stable* or you have taken any form of nitroglycerine for the relief of angina pain; and/or,
- your lung condition if, in the **six (6) months** before your effective date, it has not been *stable* or you required *treatment* with oxygen or prednisone for your lung condition.

Rate Category C. We will not pay any expenses relating to:

- a *pre-existing condition* that is not *stable* in the **twelve (12) months** before your effective date; and/or,
- your heart condition if, in the **twelve (12) months** before your effective date, it has not been *stable* or you have taken any form of nitroglycerine for the relief of angina pain; and/or,
- your lung condition if, in the **twelve (12) months** before your effective date, it has not been *stable* or you required *treatment* with oxygen or prednisone for your lung condition.

Part B • Applicant's Declaration – Please read carefully before signing

Declaration. I apply to The Manufacturers Life Insurance Company (Manulife Financial) for insurance under the Manulife Financial Travel Insurance policy. I declare that all the information I have provided on this application form, together with the Health Declaration originally attached hereto, is true and complete. I understand that this coverage is subject to terms, conditions, limitations and exclusions (including the *pre-existing condition* exclusion) and may exclude or limit an amount payable if I have a claim. I understand that if I misrepresent any material information provided in this application, Manulife Financial will void my policy and I will not be covered for any benefits under this policy. I authorize any *hospital*, physician, other medical service provider or any other organization or person that has any records or knowledge of me or my health to release to the assistance and claims service provider and/or Manulife Financial and its reinsurers any such information for the purpose of this application and contract and any subsequent claim.

Notice on Privacy and Confidentiality. The specific and detailed information requested on the application form is required to process the application. To protect the confidentiality of this information, Manulife Financial will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife Financial employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Affinity Markets, Manulife Financial, 2 Queen Street East, Toronto, Ontario M5C 3G7.

Applicant 1 Signature _____ Applicant 2 Signature _____ Date Signed _____ (MM/DD/YYYY)

Advisor's Report • For Advisor/Agent Use Only

You confirm that you have disclosed the following information to the applicant:

- the name of the company or companies you represent
- that you receive commissions for the sale of life and accident and sickness insurance products and may receive bonuses, invitations to conferences or other incentives; and
- any conflicts of interest you may have with respect to this transaction.

Your name (first, middle initial, last)	Advisor code	Signature
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Agent – Please complete this section

Agent name	Telephone number	Fax number	Agent selling code
Company name and address		Email address	Resource centre code

Part C • Insurance Application

APPLICANTS

LAST NAME, FIRST NAME 1. Applicant 1				DATE OF BIRTH (MM/DD/YYYY)	
HOME ADDRESS Street Apt No. City Province Postal Code					
HOME PHONE # ()	WORK PHONE # ()	EMAIL (optional)	COUNTRY OF DESTINATION	PHONE # AT DESTINATION ()	
LAST NAME, FIRST NAME 2. Applicant 2				DATE OF BIRTH (MM/DD/YYYY)	
HOME ADDRESS Street Apt No. City Province Postal Code					
HOME PHONE # ()	WORK PHONE # ()	EMAIL (optional)	COUNTRY OF DESTINATION	PHONE # AT DESTINATION ()	

COVERAGE SELECTION

MULTI-TRIP DURATION and EFFECTIVE DATE

Covers multiple trips during a 365-day period. **SELECT YOUR TRIP LENGTH:** 4 days 10 days 18 days 30 days

EFFECTIVE DATE: (MM/DD/YYYY)

SINGLE-TRIP DURATION

Departure Date*	(MM/DD/YYYY)
Return Date	
Total # of days in your trip ¹	

* Must be within 180 days of purchase

¹ Count the day you leave and the day you return.

TOP-UP NOTE:

If you are 55 or older, you must complete the Medical Questionnaire to determine your Rate Category.

TOP-UP DURATION

Top-Up Effective Date*	(MM/DD/YYYY)
Total # of days in your trip ¹	
Subtract # of days already covered under your policy	—
Equals Total Top-Up days	=

CALCULATE YOUR PREMIUM

Premium due for your coverage is based on the plan you are purchasing, your age, the Rate Category you qualify for and trip duration.

EMERGENCY MEDICAL

Total Emergency Medical Premium

Applicant #	Rate Category	Single-Trip or Top-Ups (# of days x daily rate applicable to your full trip length) ²	Multi-Trip Rate for the trip length you select
1		\$	\$
2		+ \$	+ \$
Total Premium (sum premium rates of each applicant)		= \$	Line A

² For Top-Up Premium use the daily rate applicable to the **TOTAL NUMBER OF DAYS IN YOUR TRIP**.

SAVINGS OPTIONS

Savings Applied

Deductible Savings: All published rates include a zero deductible. Not applicable to Travel Canada.

Deductible (\$ USD)	\$0	\$500	\$1,000	\$5,000	\$10,000		
Savings Amount	0%	15%	20%	35%	50%	%	
50% Travel Canada Emergency Medical or Quick Trip Canada Plan: Cannot be combined with a Deductible Savings.							
Calculate Savings (% x Line A)						= \$	Line B

TOTAL PREMIUM

Emergency Medical Premium (Line A minus Line B)	= \$	Line C
Travel Companion Savings (Line C x 5%)	= \$	Line D
If you need help with your premium calculation, please contact your broker/advisor.	Total Payment (Line C minus Line D)	= \$

Payment Option: Visa MasterCard AMEX Cheque

Cardholder's Name

Cardholder's Signature

Credit Card Number

Expiry Date

Note: Coverage will not take effect if your credit card number is invalid or payment is rejected for any reason.

Mail this application with your payment payable to your agent/broker or Manulife Financial Travel Insurance, P.O. Box 4262, Stn A, Toronto, ON M5W 5T4.

Manulife Financial Travel Insurance is offered through The Manufacturers Life Insurance Company (Manulife Financial).

Plans underwritten by The Manufacturers Life Insurance Company. Manulife, Manulife Financial, the Manulife Financial For Your Future logo and the Block Design are trademarks of The Manufacturers Life Insurance Company and are used by it, and by its affiliates under license. TM/® Trademarks held by The Manufacturers Life Insurance Company. ©2013 The Manufacturers Life Insurance Company. All rights reserved.