MEDIPAC
Travel Insurance

INSTRUCTIONS

These instructions have been designed for you to simplify the application process. **Read these instructions in full** before you begin.
If you have any questions, please call Medipac for further assistance at **1-800-MEDIPAC** (1-800-633-4722).

Before you begin:

- Review your policy carefully **prior** to your departure; in particular, the *"What is Not Covered"* and the *"General Limitations"* sections. Certain exclusions and/or other limitations in benefits are applicable to your coverage.
- The policy contains stability period requirements which are applicable to any **new** and/or **pre-existing** medical conditions. If you do not meet the requirements of the stability period clauses, or you are ineligible for coverage, or have a change in health after your date of application and prior to your effective date of insurance, it is important that you call us; coverage may be available through our Individual Underwritten Insurance.
- If you are unclear about **any** of your medical conditions or medications, consult your doctor.

NOTE: Trips in excess of 183 days are available to residents of **all** provinces and territories **except** QC, PEI and NU.

Completing the Application:

- The application must be filled out in full and in **pen**.
- Your emergency contact should not be the person with whom you are travelling.
- All of the medical questions in sections A, C and D must be answered unless you are under the age of 56 and travelling for less than 41 days. Changes **must** be initialled by the applicant.
- An application cannot be processed without specific departure and return dates. If you are unsure of your dates, select the dates and trip length that are closest to your estimated travel time period. When you have finalized your travel plans, call us before your departure date for your **free** policy change *(if your trip length changes, a premium adjustment may be required).*
- Your application must be **signed and dated** by both applicants (if applicable). Be sure that you **read and understand** section H. DECLARATION/AUTHORIZATION.

Skipping any of the above steps will require correction and will delay processing of your application.

Important reminders:

- You **must** have a policy number before you leave for your trip.
- If you have **any change in health** after the date you completed your application and prior to your effective date of insurance, you **must** call Medipac.
- Prior to seeking medical attention **you must call Medipac Assist.** Failure to call will result in benefits being limited *(see policy wording included).* If you are experiencing a medical emergency, call 911 first. As with all travel insurance plans, in the event of a claim, your medical records **will** be reviewed.
- Change in plans? If you are leaving before or after your original effective date you **must** notify Medipac in advance to change your dates, or your coverage will be limited.
- Staying longer than expected? Call Medipac for an extension of coverage. Extensions **must** be applied for prior to your expiry date. *(see policy extension wording included).*
- Need to cancel or coming home early? *See policy refund wording included.*

CHECKLIST

ENDORSED BY CANADIAN SNOWBIRD ASSOCIATION csa

Before you submit your application, ensure that:

- ☐ All medical questions have been answered and any changes made to the application have been initialled by the individual applying for insurance.
- ☐ You have indicated your departure and return dates, trip length and deductible.
- ☐ Each applicant has signed and dated section H with the date the application was actually signed.
- ☐ Your payment is included. *Full payment must be received prior to departure, or your policy will not be valid. NSFs will be charged $25.*

To Pay In Full:

- Include a cheque payable to Medipac Travel Insurance or complete the credit card information in section I.

To Pay in 2 Equal Instalments (only available with payment by cheque):

- To take advantage of the 2-instalment option, include one cheque marked VOID (post-dated cheques are not required).
- The first of your 2 payments will be collected on the date your application is processed. The balance of your premium will be collected one month following that date.

MEDIPAC

TRAVEL EMERGENCY MEDICAL INSURANCE APPLICATION 2024-2025

If you are travelling for less than 41 days and you are under the age of 56, you do not have to complete sections A, C and D of this application.
If you are uncertain of your answer to any of the medical questions, consult your doctor.

A. ELIGIBILITY

			APPLICANT 1 YES	APPLICANT 1 NO	APPLICANT 2 YES	APPLICANT 2 NO
1	**Have you** been diagnosed as having a terminal illness or have you been advised by a physician not to travel?	1	YES	NO	YES	NO
2	**Have you** been diagnosed with pulmonary fibrosis or interstitial lung disease?	2	YES	NO	YES	NO
3	**Have you EVER** had an organ or bone marrow transplant (**excluding** cornea or skin graft) **or** a blood disorder for which you have received stem cell treatment?	3	YES	NO	YES	NO
4	**During the 5 YEARS** prior to the date of this application, have you been treated for, taken or been prescribed medication for, or been diagnosed with lung cancer, metastatic cancer or two (2) or more cancers (**excluding** basal cell and squamous cell skin cancer)?	4	YES	NO	YES	NO
5	**Do you HAVE** a cardiac condition with an ejection fraction of **LESS THAN 41%** or a ventricular function grade of **3 or 4**?	5	YES	NO	YES	NO
6	**Do you HAVE** moderately severe or severe cardiac valve stenosis?	6	YES	NO	YES	NO
7	**Do you HAVE** an aneurysm or dilated artery greater than 4.5 cm in size (diameter or width) which remains surgically untreated?	7	YES	NO	YES	NO
8	**During the 6 MONTHS** prior to the date of this application, have you:					
	a undergone chemotherapy, immunotherapy or targeted drug therapy for cancer or malignant tumour(s)?	8a	YES	NO	YES	NO
	b had surgery or stenting on **ANY** artery **or** cardiac pacemaker implant surgery?	8b	YES	NO	YES	NO
9	**During the 12 MONTHS** prior to the date of this application have you:					
	a had cardiac ablation, cardiac defibrillator implant surgery, coronary angioplasty and/or stent, coronary bypass surgery, cardiac valve replacement or repair, had a heart attack, a cardiac arrest or an episode of congestive heart failure?	9a	YES	NO	YES	NO
	b had a stroke, a transient ischemic attack (TIA) or a ministroke?	9b	YES	NO	YES	NO
	c had **ANY** chronic lung disease (**including** emphysema, chronic obstructive pulmonary disease [COPD], chronic bronchitis, reactive airway disease or asthma) which caused you to be hospitalized for more than 24 consecutive hours, or for which you have taken or been prescribed prednisone or Solu-Medrol?	9c	YES	NO	YES	NO
	d taken or been prescribed home oxygen for any reason?	9d	YES	NO	YES	NO
	e taken or been prescribed insulin or two (2) or more medications for diabetes **AND** medication for a heart condition? ***If medication is taken or prescribed for only one condition, answer "No" to this question.*** The term "medication" includes nitroglycerin in any form. Hypertension (high blood pressure) is not considered a heart condition.	9e	YES	NO	YES	NO

STOP IF YOU ANSWERED **YES** TO **ANY** QUESTION ABOVE, **YOU ARE NOT ELIGIBLE**. Call us, we can help. **1-877-888-5259.**

GO IF YOU ANSWERED **NO** TO **ALL** QUESTIONS ABOVE, **YOU ARE ELIGIBLE**. Continue your application.

B. PERSONAL INFORMATION

Please Print

APPLICANT 1			APPLICANT 2		
Given Name and Surname:			Given Name and Surname:		
Date of Birth: Day: _____ Month: _____ Year: _____	Male ☐	Female ☐	Date of Birth: Day: _____ Month: _____ Year: _____	Male ☐	Female ☐
Have you smoked cigarettes or used vaping products (including e-cigarettes) in the 2 years prior to the date of this application?	Yes ☐	No ☐	**Have you smoked cigarettes or used vaping products (including e-cigarettes) in the 2 years prior to the date of this application?**	Yes ☐	No ☐
Doctor's Name:	Phone: ( )		Doctor's Name:	Phone: ( )	
Specialist's Name *(if any):*	Phone: ( )		Specialist's Name *(if any):*	Phone: ( )	
Specialty Type:			Specialty Type:		
Emergency Contact Person not travelling with you:	Phone: ( )		Emergency Contact Person not travelling with you:	Phone: ( )	

CANADIAN ADDRESS *(Both Applicants)*			OUT-OF-COUNTRY ADDRESS *(Both Applicants, if applicable)*		
Street Name & Number:		Apt # or Lot #:	Street Name & Number:		Apt # or Lot #:
City:	Province:	Postal Code:	City:	State:	Zip Code:
E-mail:			E-mail:		
Phone: ( )		Cell: ( )	Phone: ( )		Cell: ( )

Please mail my insurance policy to my: ☐ Canadian Address ☐ Out-of-Country Address

C. RATE QUALIFICATION - PART 1

			APPLICANT 1 YES NO	APPLICANT 2 YES NO
1	**Have you EVER** had congestive heart failure or heart surgery of **ANY** kind (**including** cardiac ablation, cardiac pacemaker/ defibrillator implant, coronary angioplasty and/or stent, coronary bypass surgery, cardiac valve replacement or repair)?	1	YES NO	YES NO
2	**During the 5 YEARS** prior to the date of this application, have you been treated for, taken or been prescribed medication for, or been diagnosed with:			
	a ANY heart condition (**including** atrial fibrillation, irregular heart beat, angina or heart attack), narrowing or blockage of **ANY** artery (**including** pulmonary embolism [PE], peripheral artery disease [PAD] or carotid stenosis), or pulmonary hypertension?	2a	YES NO	YES NO
	b chronic lung disease (**including** emphysema, chronic obstructive pulmonary disease [COPD] or chronic bronchitis)?	2b	YES NO	YES NO
	c a stroke, a transient ischemic attack (TIA), a ministroke or amaurosis fugax (**excluding** treatment with aspirin)?	2c	YES NO	YES NO
3	**During the 3 YEARS** prior to the date of this application, have you been treated for, taken or been prescribed medication for, or been diagnosed with chronic bowel disease or disorder (**including** colitis, Crohn's disease, diverticulitis or irritable bowel syndrome), pancreatitis or gastrointestinal bleeding?	3	YES NO	YES NO
4	**During the 12 MONTHS** prior to the date of this application, have you been treated for, taken or been prescribed medication for, or been diagnosed with cancer or malignant tumour(s) (**excluding** basal cell and squamous cell skin cancer)? The term "medication" **excludes** tamoxifen and **ANY** other hormone treatment.	4	YES NO	YES NO
5	**During the 12 MONTHS** prior to the date of this application, have you taken or been prescribed two (2) or more inhalers (**including** a rescue inhaler)?	5	YES NO	YES NO
6	**During the 3 MONTHS** prior to the date of this application, have you taken or been prescribed:			
	a corticosteroids (**including** prednisone and Solu-Medrol) for more than 15 days (**excluding** inhalers, topical medications and eye drops)?	6a	YES NO	YES NO
	b a total of 3 or more medications for diabetes (**including** glucose intolerance), hypertension (high blood pressure) or both? The term "medication" includes diuretics (water pills).	6b	YES NO	YES NO
7	**Have you been diagnosed with** Lou Gehrig's disease (ALS), muscular dystrophy, myasthenia gravis, cerebral palsy, multiple sclerosis or dementia (**including** Alzheimer's disease)?	7	YES NO	YES NO
8	**Do you HAVE** reduced kidney function with an eGFR of less than 45 **or** cirrhosis of the liver?	8	YES NO	YES NO
9	**Do you HAVE** diabetes requiring insulin?	9	YES NO	YES NO

D. RATE QUALIFICATION - PART 2

			APPLICANT 1 YES NO	APPLICANT 2 YES NO
1	**Have you EVER** had narrowing or blockage of **ANY** artery (**including** pulmonary embolism [PE], peripheral artery disease [PAD] or carotid stenosis), an aneurysm, pulmonary hypertension, or **ANY** heart condition (**including** atrial fibrillation, irregular heart beat, a heart attack or angina)?	1	YES NO	YES NO
2	**Have you EVER** had a stroke, a transient ischemic attack (TIA) or a ministroke?	2	YES NO	YES NO
3	**Do you HAVE** diabetes (**including** glucose intolerance) requiring medication?	3	YES NO	YES NO
4	**During the 2 YEARS** prior to the date of this application, have you been treated for, taken or been prescribed medication for, or been diagnosed with:			
	a a blood disorder by an Internist or a Hematologist?	4a	YES NO	YES NO
	b epilepsy or any other seizure disorder (**including** an untreated episode)?	4b	YES NO	YES NO
	c Parkinson's disease or Parkinson's syndrome?	4c	YES NO	YES NO
5	**During the 12 MONTHS** prior to the date of this application, have you had a fainting spell or a syncopal episode?	5	YES NO	YES NO
6	**During the 3 MONTHS** prior to the date of this application, have you taken or been prescribed:			
	a anticoagulants (blood thinners) or antiplatelets (**excluding** aspirin)?	6a	YES NO	YES NO
	b Lasix or furosemide?	6b	YES NO	YES NO
	c any immunosuppressive drugs (**excluding** methotrexate)?	6c	YES NO	YES NO

WHICH PLAN DO YOU QUALIFY FOR?

If you answered **NO** to **ALL** of the questions in section C and D,	If you answered **NO** to **ALL** of the questions in section C but **YES** to **ANY** of the questions in section D,	If you answered **YES** to **ANY** of the questions in section C,
YOU QUALIFY FOR **THE PREFERRED PLUS PLAN**	YOU QUALIFY FOR **THE PREFERRED PLAN**	YOU QUALIFY FOR **THE STANDARD PLAN**

MEDIPAC Travel Insurance

NEED HELP? Call 1-800-MEDIPAC

1-800-633-4722 •(416) 441-7070 in the GTA • Fax # (416) 441-7030

Medipac Travel Insurance, 180 Lesmill Road, Toronto, ON M3B 2T5 • www.medipac.com

Underwritten by

Old Republic Insurance Company of Canada

Administered by Medipac International Inc.

2024MSOLE

E. TRAVEL INFORMATION

If you are taking multiple trips, provide details on a separate piece of paper.

APPLICANT 1	SINGLE TRIP DETAILS	APPLICANT 2

Must be completed even if topping up.

Date of Departure: Day: _____ Month: _____ Year: _____	☐ Same as applicant 1 Date of Departure: Day: _____ Month: _____ Year: _____
Scheduled Return Date: Day: _____ Month: _____ Year: _____	Scheduled Return Date: Day: _____ Month: _____ Year: _____

OTHER INSURANCE COVERAGE

If you have other Insurance with similar out-of-country benefits, provide details. Must be completed if topping up, or applying for Federal Superannuate Credit.

☐ I am a **Superannuate** and I request that my policy be issued with a deductible of $1,000,000 CAD for the first 40 days of my trip.	☐ I am a **Superannuate** and I request that my policy be issued with a deductible of $1,000,000 CAD for the first 40 days of my trip.
☐ I am **topping up** my other insurance and request that my Medipac Effective Date be: Day:____ Month:____Year:____	☐ I am **topping up** my other insurance and request that my Medipac Effective Date be: Day:____ Month:____Year:____

Name of Plan:	Number of days covered:	Name of Plan:	Number of days covered:
Insurance Company:	☐ Single Coverage ☐ Family Coverage	Insurance Company:	☐ Single Coverage ☐ Family Coverage
Policy #:	Certificate #	Policy #:	Certificate #

NUMBER OF DAYS APPLIED FOR (see rate tables for trip lengths)

3	6	9	12	15	18	21	24	27	30	33	36	40	50	60	66	75
82	90	96	105	112	120	126	135	142	150	156	165	175	183	190	200	212

3	6	9	12	15	18	21	24	27	30	33	36	40	50	60	66	75
82	90	96	105	112	120	126	135	142	150	156	165	175	183	190	200	212

ANNUAL ADD-ON

☐ I am purchasing the **Annual Add-on:** ☐ **23-day** ☐ **33-day**	☐ I am purchasing the **Annual Add-on:** ☐ **23-day** ☐ **33-day**
☐ A. to start on my Effective Date of Insurance, **OR**	☐ A. to start on my Effective Date of Insurance, **OR**
☐ B. to start on Day:_____ Month:_____ Year:_____	☐ B. to start on Day:_____ Month:_____ Year:_____

For Option B, this date must be between the date your application is processed and your Effective Date of Insurance.
You must buy a minimum 22-24 day trip to purchase the 23-day Annual Add-on or a minimum 31-33 day trip to purchase the 33-day Annual Add-on.

MedipacMAX / MedipacPLUS

YES ☐ Add Medipac**MAX** ☐ Add MedipacPLUS	**YES** ☐ Add Medipac**MAX** ☐ Add MedipacPLUS

F. PREMIUM CALCULATION

Rate Category:	☐ **Preferred PLUS**	☐ **Preferred**	☐ **Standard**	**Rate Category:**	☐ **Preferred PLUS**	☐ **Preferred**	☐ **Standard**
Select USD Deductible:	☐$0	☐$99	☐$1,000 ☐$5,000 ☐$10,000	**Select USD Deductible:**	☐$0	☐$99	☐$1,000 ☐$5,000 ☐$10,000

Age at Departure:		Age at Departure:	
Single Trip Rate for Applicant 1:		Single Trip Rate for Applicant 2:	
SUBTRACT Total discount (_____) %	–	**SUBTRACT** Total discount (_____) %	–
ADD Annual Add-on Rate ***(if applicable)***:	+	**ADD** Annual Add-on Rate ***(if applicable)***:	+
Rate Subtotal:	=	**Rate Subtotal:**	=
ADD 10% if taking a $0 Deductible:	+	**ADD** 10% if taking a $0 Deductible:	+
Subtotal:	=	**Subtotal:**	=
ADD 20% if you have smoked cigarettes or used vaping products in the 2 years prior to the date of this application:	+	**ADD** 20% if you have smoked cigarettes or used vaping products in the 2 years prior to the date of this application:	+
SUBTRACT Federal Superannuate Credit ***(if applicable)***:	–	**SUBTRACT** Federal Superannuate Credit ***(if applicable)***:	–
ADD $147 for MedipacMAX ***(recommended)*** or $59 for MedipacPLUS:	+	**ADD** $147 for MedipacMAX ***(recommended)*** or $59 for MedipacPLUS:	+
Total Premium for Applicant 1:	=	**Total Premium for Applicant 2:**	=

G. PAYMENT OPTION

Premiums are in Canadian dollars

☐ **OPTION 1: Pay in Full.**	☐ **OPTION 2: Pay by Instalments.** *See instructions for details.*
Make your cheque payable to Medipac Travel Insurance or fill out the credit card information in section I.	50% of your premium will be collected on the date your application is processed; the balance will be collected one month following that date. **Include a VOID cheque with your application.**

THIS BOX IS FOR ADMINISTRATION USE ONLY

APPLICANT 1 POLICY #	CHECKED BY:_____ PROCESSED BY:_____	APPLICANT 2 POLICY #

NOTES: _____

_____

_____

_____

H. DECLARATION/AUTHORIZATION

This application must be completed in full, dated, and signed within Canada prior to departure. Medipac reserves the right to refuse any application.

If I do not date this application, then the date on which Medipac receives this completed application will be considered as the date signed.

I, the undersigned, understand that obtaining travel emergency medical insurance coverage under the policy is dependent on the accuracy of the information that I provide in this application. **I acknowledge that** it is my responsibility to be fully aware of my medical history, and that **I am advised** to consult with my doctor(s) and have had the opportunity to verify the accuracy of the information which I provide herein.

I certify that all answers and information I provide in this application are complete, true, and accurate.

IMPORTANT NOTICE: All answers in this application must be and remain true up to and including the Effective Date of Insurance. **Should my health change** in any way (including any new or changed diagnosis) and/or should I have any investigations or seek medical attention between the date of this application and the Effective Date of Insurance, **I agree** to promptly notify Medipac International Inc. (Medipac). Medipac will reassess my eligibility and may adjust my premium accordingly. Failure to update Medipac may result in limited coverage, a claim denied and/or the policy deemed **null and void.**

I understand that in the event that I experience a medical emergency, seek medical attention and/or submit a claim under the policy, my medical records may be required and reviewed. **I understand that** if it is determined that any information I provide is misleading, is contrary to my medical records, or is inaccurate, coverage may be limited, a claim denied and/or the policy deemed **null and void**.

I acknowledge having received a copy of this application and the policy. Furthermore, **I affirm that** I have read, understand, and agree to the terms and conditions of the policy, including the General Exclusions, General Limitations and those related to Unstable Pre-existing Conditions; including, among other things, any medical conditions **1) that were NOT stable and controlled**, including any reaction to a change in medication, during the 90 days prior to my requested Effective Date of Insurance (or any Trip Start Date under the Annual Add-on); or **2) which required** a total of three [3] or more emergency room visits, hospitalizations, day surgeries or any combination of all three, **and/or** a single hospitalization for more than 48 consecutive hours, in the 12 months prior to my requested Effective Date of Insurance (or any Trip Start Date under the Annual Add-on); or **3) for which treatment** and/or investigation(s) were recommended but not received prior to my requested Effective Date of Insurance (or any Trip Start Date under the Annual Add-on).

I acknowledge and agree that by submitting this application, access to and use of my personal information will be governed by both Medipac's Privacy Policy, available at www.medipac.com/privacy-policy, and Old Republic Insurance Company of Canada's (the Company) NOTICE ON PRIVACY, available at www.orican.com/privacy.

In the event I experience a medical emergency, seek medical attention or submit a claim, **I hereby authorize** any physician, practitioner, health-care provider, hospital, health-care institution, medical organization, clinic and any other medical or medically related facility, insurance company, Workers' Compensation Board or similar plan or organization and any Ministry of Health to release and exchange with Medipac, Medipac Assist and the Company, or representatives thereof, my complete medical records, including medical treatment provided by my primary care physician and treatment I received, am about to receive or may receive in the future. I authorize the period of 12 months from the date of my notice of claim as the period of access to, and disclosure of, my individually identifiable health information in accordance with the Canadian PIPEDA (Personal Information Protection and Electronic Documents Act) and U.S. HIPAA (Health Insurance Portability and Accountability Act) Privacy Practices. A photocopy or electronic copy of this authorization shall be as valid as the original.

In the event of a claim, where applicable, I authorize that my deductible be charged to the credit card number used to purchase the policy. If expenses are less than the deductible, a refund will be issued.

DATE and SIGN below

X _____
Signature of Applicant 1

X _____
Signature of Applicant 2

_____
Applicant 1 - print name in full

_____
Applicant 2 - print name in full

X **Date Signed: Day** _____ **Month** _____ **Year** _____

I. CREDIT CARD PAYMENT OPTION

All premiums are in Canadian dollars

Cardholder Name:	☐ Visa	☐ MasterCard
Card #:	Expiry Date Month:	Year: