

EMERGENCY MEDICAL QUESTIONNAIRE - AGE 60 OR OVER ON THE DATE YOU PURCHASE THIS INSURANCE

MEDICAL QUESTIONNAIRE must be completed by all applicants who are applying for "Plan B. Emergency Medical" or "Plan D. Annual Medical" and are: 1) age 60 to 74 travelling for 31 days or more; or 2) age 75 or older travelling for any duration. ABOUT THE MEDICAL QUESTIONS – If you are uncertain of your answers to any of the medical questions, please consult your doctor before completing this application for insurance.

STEP 1. PERSONAL INFORMATION (Please PRINT)

Surname and Given Names of Applicants

Gender
M/F

Date of Birth
(mm/dd/yy)

1.		
2.		

STEP 2. ELIGIBILITY

	Applicant 1	Applicant 2
1. Are you travelling against the advice of a physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever had or are you awaiting a bone marrow, stem cell, or organ transplant (excluding corneal transplant)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Within the past 24 months, have you:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) used or been prescribed home oxygen, or Lasix or furosemide for any reason?		
(b) required kidney dialysis?		
(c) been newly diagnosed with, or experienced a change in symptoms, a change in treatment or a change in prescription medication for: stroke, T.I.A. (transient ischemic attack), heart condition, blocked or narrowed arteries in the legs (peripheral vascular disease), diabetes treated with medication and/or insulin, chronic obstructive pulmonary disease, chronic bronchitis, emphysema, or metastatic cancer?		
4. Have you had heart bypass surgery, angioplasty or heart valve surgery more than 10 years ago?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you answered YES to ANY of the above questions, you are NOT eligible to purchase this insurance. If you answered YES to questions 3, 4 or 5, contact your agent to obtain a quote for our Individual Medical Underwriting Plan. If you answered NO to all of the above questions, you are eligible to purchase this insurance. Proceed to Step 3 to Find your Rate Category.		

STEP 3. FIND YOUR RATE CATEGORY

5. In the last 10 years, have you been diagnosed with or had an investigation, medical consultation, been prescribed medication or received treatment for a heart condition or had a pacemaker or defibrillator implant, stent placement, ablation or valve surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Within the past 24 months, have you been diagnosed with, and/or had treatment 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 conditions:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) Stroke or T.I.A. (transient ischemic attack), or Syncope (fainting spells)?		
(b) Narrowing or blockage of any arteries; or aneurysm?		
(c) Chronic obstructive pulmonary disease, chronic bronchitis or emphysema?		
(d) Cancer (excluding basal or squamous cell skin cancer, and breast cancer treated only with hormonal therapy)?		
(e) Diabetes (treated with medication and/or insulin)?		
(f) Alzheimer's disease or any other form of dementia, Parkinson's disease or multiple sclerosis?		
(g) Chronic bowel disorder, bowel obstruction or surgery, gastrointestinal bleeding, diverticular disorder requiring prescription medication or surgery, or pancreatic disorder?		
(h) Kidney disorders, hepatitis or cirrhosis of the liver?		
7. Within the past 12 months, have you been newly diagnosed with, or experienced a change in symptoms or a change in prescription medication for high blood pressure or asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you answered NO to ALL of the above questions you qualify for PREFERRED rates. If you answered YES to ANY of the questions in Step 3, Find Your Rate Category, you qualify for STANDARD rates.		

STEP 4. DECLARATION, AUTHORIZATION and NOTICE ON PRIVACY

All Applicants must read the following statements and sign below

I declare that all the information I have provided on this Medical Questionnaire for 21st Travel Insurance is true and complete. I understand that the 21st Century Travel Insurance policy is subject to the terms, conditions limitations, and exclusions (including the pre-existing condition exclusion) applicable to my coverage and may limit or exclude an amount payable. I understand that if I misrepresent any material information provided in this application, Manulife, the underwriter of this insurance policy, 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 and its reinsurers and/or 21st Century Travel Insurance Limited 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 this medical questionnaire is required to process the application. To protect the confidentiality of this information, Manulife 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 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, Manulife, P.O. Box 1602, Del. Stn. 500-4-A, Waterloo, Ontario N2J 4C6.

Applicant 1 Signature: _____ Applicant 2 Signature: _____ Date: _____