

# MEDICAL QUESTIONNAIRE

## For Trip Cancellation & Interruption in excess of \$15,000

This form must be completed by each person requiring a total Prior Departure Sum Insured in excess of \$15,000 under Trip Cancellation & Interruption (Basic and Select Plans) and All-inclusive Package Plans. Your application must be approved by TIC Underwriting before a policy can be issued.

### Applicant Information

Last name: \_\_\_\_\_ First name: \_\_\_\_\_  
 Male  Female Date of Birth: MM/DD/YYYY

### Your Mailing Address

Street: \_\_\_\_\_ Apt No.: \_\_\_\_\_  
 City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Phone: ( ) \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

### Travel Plan

Plan Type:  Basic  Select  USA Package  Non-USA Package \_\_\_\_\_

Total Prior to Departure Sum to be Insured: (the final cost of the trip) \_\_\_\_\_

Was any portion of the trip booked through a non-Canadian agency?  Yes  No

Provide details: \_\_\_\_\_

Destination: (Attach detailed itinerary) \_\_\_\_\_ Departure Point: \_\_\_\_\_

No. of Travel Companions: \_\_\_\_\_ Is this an organized group trip?  Yes  No

Provide details: \_\_\_\_\_

Application Date: MM/DD/YYYY Departure Date: MM/DD/YYYY Return Date: MM/DD/YYYY

Deposit Date: MM/DD/YYYY Partial Penalty Date(s): MM/DD/YYYY Full Penalty Date: MM/DD/YYYY

Mode of Transport: \_\_\_\_\_ If privately owned vessel, provide details: \_\_\_\_\_

Name of Carrier: \_\_\_\_\_

Other Notes: \_\_\_\_\_

### Agent Information

Agency name: \_\_\_\_\_ Agency Code: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Agent's name: \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Email: \_\_\_\_\_

Other Notes: \_\_\_\_\_

## Questions

**IMPORTANT:** This application forms part of your policy. Non-disclosure or misrepresentation of any fact that affects our decision regarding this coverage shall make it voidable by us. Approval of this application will not vary, alter, waive or extend any provision or condition of the policy except where approval of coverage is subject to endorsement, which attaches to your policy.

1. Within the 90 days immediately preceding this application, have you received any medical treatment, been admitted to hospital for, or sought medical consultation for any medical condition?  **Yes**  **No**

a) If yes, please describe fully the medical condition:

\_\_\_\_\_

b) Description and nature of treatment received:

\_\_\_\_\_

c) When was your last treatment received?

\_\_\_\_\_

d) Name the test/investigation and the date performed:

\_\_\_\_\_

e) Name and date the pending tests/investigations:

\_\_\_\_\_

2. Are you currently taking any prescription medications?  **Yes**  **No** If yes, please provide details below:

NAME OF MEDICATION	REASON PRESCRIBED	DATE PRESCRIBED AND LAST DOSAGE CHANGE
_____	_____	MM/DD/YYYY
_____	_____	MM/DD/YYYY
_____	_____	MM/DD/YYYY
_____	_____	MM/DD/YYYY
_____	_____	MM/DD/YYYY
_____	_____	MM/DD/YYYY

List all hospitalizations and surgeries in the last twelve months:

MEDICATION CONDITION	HOSPITALIZATION/SURGERY	DATE
_____	_____	MM/DD/YYYY
_____	_____	MM/DD/YYYY
_____	_____	MM/DD/YYYY
_____	_____	MM/DD/YYYY
_____	_____	MM/DD/YYYY

3. Do you know of any reason that could prevent you from travelling as scheduled?  **Yes**  **No**

a) If yes, provide details:

\_\_\_\_\_

\_\_\_\_\_

4. Do you know of any family member or travelling companion who has any medical condition?  **Yes**  **No**

5. Are you aware of any other reason that this trip may be cancelled?  **Yes**  **No**

a) If yes, provide details:

\_\_\_\_\_

\_\_\_\_\_

## Authorization & Declaration

### 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 that:

- 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.

### Please sign here

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

**If you made any corrections to your answers, please initial the corrections where they appear.**

\_\_\_\_\_  
Your Name (please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (mm/dd/yyyy)