Manulife

Manulife Financial
Travel Insurance

MEDICAL QUESTIONNAIRE FOR TRAVELLING CANADIANS AGE 60 OR OVER ONLY

NAME OF APPLICANTS

Applicant 1	Date of Birth	Applicant 2	Date of Birth
Last Name First Name		Last Name First Name	

ABOUT THE MEDICAL QUESTIONS – Medical questions help us to determine your eligibility and premium rate. If you are uncertain of your answers to any of the medical questions, please consult your doctor before completing this application for insurance.

Treatment, Treated, as used in this questionnaire, means hospitalization, prescribed medication (including medication prescribed "as needed"), medical, therapeutic, diagnostic or surgical procedure prescribed, performed or recommended by a licensed medical practitioner. **IMPORTANT:** Any reference to testing, tests, test results, or investigations excludes genetic tests. "Genetic test" means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.

Step 1 • ARE YOU ELIGIBLE FOR COVERAGE ?

You must be a Canadian resident covered by the Government Health Insurance Plan in your province or territory of residence for the entire duration of your trip. Coverage is NOT AVAILABLE under this policy or the Individual Medical Underwritten plan to any person who:

- is travelling against the advice of a physician;
- is diagnosed with a terminal illness or metastatic cancer;
- requires kidney dialysis;
- has been prescribed or used home oxygen in the last twelve (12) months;
- has had a bone marrow, stem cell or organ transplant (excluding cornea).

If you are not eligible to purchase this insurance, DO NOT complete this application.

Step 2 • YOUR DECLARATION – PLEASE READ CAREFULLY

I am eligible to apply to The Manufacturers Life Insurance Company (Manulife) for insurance under the Manulife Financial Travel Insurance policy. I declare that all the information I am providing on this application is true and complete. I understand the meaning of *treatment/treated*, as defined and used in this questionnaire.

I understand this coverage is subject to terms, conditions, limitations and exclusions (including the pre-existing condition exclusion); and, that this coverage 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 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 any such information for the purpose of this application and contract and any subsequent claim.

By proceeding to Step 3, you are indicating that you are eligible to apply and that you have read and agree with the contents of the above Declaration.

Step 3 • DO YOU REQUIRE INDIVIDUAL MEDICAL UNDERWRITING?	**Applicant 1**	**Applicant 2**
1. Have you had a heart bypass, coronary angioplasty or heart valve surgery **more than ten (10) years ago?**	❑ Yes ❑ No	❑ Yes ❑ No
2. In the last **three (3) years**, have you been diagnosed with, taken or been prescribed medication, or been *treated* for **any two (2)** of the following? (if you only have one (1) of the following conditions, answer NO) • Heart condition; • Lung condition (except unrepeated prescription medications used for a single episode) (medication includes any puffer(s)/inhaler(s)); • Stroke/CVA (cerebrovascular accident) or mini-stroke/TIA (transient ischemic attack) (medication includes use of aspirin/Entrophen for this condition); • Diabetes (*treated* with medication and/or insulin); • Narrowed or blocked artery in the legs (also called Peripheral Vascular Disease).	❑ Yes ❑ No	❑ Yes ❑ No
3. In the last **two (2) years**, have you been: a) diagnosed with, taken or been prescribed medication, or been *treated* for heart failure or congestive heart failure; and/or b) prescribed or taken Lasix or furosemide or a water pill for ankle or leg swelling or water on the lungs?	❑ Yes ❑ No ❑ Yes ❑ No	❑ Yes ❑ No ❑ Yes ❑ No
4. In the last **twelve (12) months**, have you had: a) a new heart condition, or had an existing heart condition for which you had a change in medication or were hospitalized (as an inpatient or seen in the emergency department); and/or b) investigative testing or *treatment* for shortness of breath or chest pain; and/or c) a lung condition for which you were hospitalized (as an inpatient or seen in the emergency department) or for which you have been prescribed or taken prednisone; and/or d) cancer or received chemotherapy and/or radiotherapy and/or other *treatment*, other than routine follow-up, for cancer (except basal cell and squamous cell skin cancer, and breast cancer *treated* only with hormonal therapy)?	❑ Yes ❑ No ❑ Yes ❑ No ❑ Yes ❑ No ❑ Yes ❑ No	❑ Yes ❑ No ❑ Yes ❑ No ❑ Yes ❑ No ❑ Yes ❑ No
5. 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.	❑ Yes ❑ No	❑ Yes ❑ No

If you must answer "**YES**" to ANY of the above questions, **you are not eligible** to purchase this insurance. Please contact your agent/broker to apply for our Individual Medical Underwriting plan for coverage of your pre-existing conditions.

If you answered "**NO**" **to ALL** of the above questions, you are eligible to purchase this insurance. Proceed to Step 4 to **FIND YOUR RATE CATEGORY**.

Step 4 • FIND YOUR RATE CATEGORY

Part 1 • SMOKING STATUS	Applicant 1	Applicant 2
1. In the last **two (2) years**, have you smoked cigarettes?	❑ Yes ❑ No	❑ Yes ❑ No

Proceed to Step 4 • Part 2

Part 2 • RATE QUALIFICATION	Applicant 1	Applicant 2
1. Have you **ever** been diagnosed with or *treated* for: a) a heart condition; and/or b) any of the following conditions;	❑ Yes ❑ No	❑ Yes ❑ No
• Aortic aneurysm (including thoracic or abdominal aneurysm)	❑ Yes ❑ No	❑ Yes ❑ No
• Cirrhosis of the liver;	❑ Yes ❑ No	❑ Yes ❑ No
• Parkinson's disease;	❑ Yes ❑ No	❑ Yes ❑ No
• Alzheimer's disease or other form of dementia?	❑ Yes ❑ No	❑ Yes ❑ No
2. 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)?	❑ Yes ❑ No	❑ Yes ❑ No
3. In the last **five (5) years**, have you been diagnosed with, taken or been prescribed medication for, or been *treated* for any of the following:		
• Lung condition (except unrepeated prescription medications used for single episode) (medication includes any puffer(s)/inhaler(s));	❑ Yes ❑ No	❑ Yes ❑ No
• Stroke/CVA (cerebrovascular accident) or mini-stroke/TIA (transient ischemic attack) (medication includes use of aspirin/Entrophen for this condition);	❑ Yes ❑ No	❑ Yes ❑ No
• Diabetes (if *treated* with medication and/or insulin);	❑ Yes ❑ No	❑ Yes ❑ No
• Narrowed or blocked artery in the legs or in the neck?	❑ Yes ❑ No	❑ Yes ❑ No

If you answered "**YES**" to ANY questions in Step 4 • Part 2, you qualify for Rate Category C.
If you answered "**NO**" to ALL questions in Step 4 • Part 2, you must answer the questions in Step 4 • Part 3.

Part 3 • RATE QUALIFICATION	Applicant 1	Applicant 2
1. In the last **two (2) years**, have you been diagnosed with, taken or been prescribed medication, or *treated* for any of the following conditions?		
• Gastrointestinal bleeding **or** bowel obstruction or have had bowel surgery;	❑ Yes ❑ No	❑ Yes ❑ No
• Chronic bowel disorder (such as but not limited to Crohn's disease or Ulcerative colitis);	❑ Yes ❑ No	❑ Yes ❑ No
• Kidney disorder (including stones) **or** Liver disorder **or** Pancreatitis;	❑ Yes ❑ No	❑ Yes ❑ No
• Gallbladder disorder (including stones. Not applicable if gallbladder has been removed.)	❑ Yes ❑ No	❑ Yes ❑ No
2. In the last **two (2) years**, have you been diagnosed with, and/or *treated* by a Hematologist or an Internist for a blood disorder?	❑ Yes ❑ No	❑ Yes ❑ No
3. Are you over 70, **and** have you had a fall for which you sought medical attention in the last **six (6) months**?	❑ Yes ❑ No	❑ Yes ❑ No
4. In the last **six (6) months**, have you received advice or *treatment* **more than twice** in the emergency room of a hospital?	❑ Yes ❑ No	❑ Yes ❑ No

If you answered "**YES**" to ANY question in Step 4 • Part 3, you qualify for Rate Category B.
If you answered "**NO**" to ALL questions in Step 4 • Part 3, you qualify for Rate Category A.

YOUR SIGNATURE CONFIRMS YOUR DECLARATION, ELIGIBILITY, AND RESPONSES TO ALL MEDICAL QUESTIONS WITHIN THIS DOCUMENT.

Applicant 1: _____ **Applicant 2:** _____ **Date:** _____

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

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