21st CENTURY VISITORS TO CANADA INSURANCE APPLICATION
Version V09 (V09-1809)

Return this form to:
DAVID CUMMINGS INSURANCE SERVICES LTD.
350-2083 Alma Street
Vancouver, BC V6R 4N6
info@david-cummings.com

STEP 1. PERSONAL INFORMATION

Last Name of Applicant(s)	First Name	Date of Birth (mm/dd/yy)	Gender M/F
1.			
2.			

Country of Origin:		**Name of Sponsor:**	
Address in Canada :			**Email:**
City:	**Prov:**	**Postal Code:**	**Phone:**

Check ☑ one only ☐ New Immigrant ☐ Returning Canadian ☐ Visitor ☐ Work/Student Visa ☐ PG-1 SuperVisa

Most recent prior 21st Century Travel Insurance policy number relating to the *current* visit : _____

STEP 2. ELIGIBILITY – Confirm all applicants are eligible for this policy. Applicants are not eligible to purchase this insurance if they:

a) are travelling against the advice of a physician and/or;
b) have been diagnosed with a terminal illness with less than two (2) years to live; and/or
c) have been diagnosed with or received treatment within the last two (2) years for pancreatic, lung, brain, or liver cancer; or any type of cancer that has spread from one part or organ of the body to another (metastatic cancer); and/or
d) have a kidney condition requiring dialysis; and/or
e) have used home oxygen during the 12 months prior to the date of application; and/or
f) have had or are waiting for an organ or bone marrow transplant (excluding corneal transplant); and/or
g) reside in a nursing home, other long term care or rehabilitation centre.

STEP 3. MEDICAL DECLARATION *(Complete only if age 55 to 85 on Effective Date)*

Answer the following questions to determine eligibility.	Applicant 1	Applicant 2
1) In relation to any heart or lung condition, shortness of breath, chest pain, stroke or mini-stroke (Transient Ischemic Attack/TIA), have you within the last **12 months**: a) been newly diagnosed, b) been prescribed any new medication or any change in dosage, frequency or type of medication, c) had any new treatment or any change in treatment (including investigation or testing), d) been referred to a specialist physician for investigation or testing, or e) been hospitalized or been seen in the emergency department of a hospital?	**YES ☐ NO ☐**	**YES ☐ NO ☐**
2) Have you: a) had heart bypass or valve surgery or angioplasty more than 10 years ago? (use the date of your most recent procedure); b) been diagnosed with a heart valve disorder which has not been treated by heart valve surgery	**YES ☐ NO ☐**	**YES ☐ NO ☐**
3) Have you ever been diagnosed with congestive heart failure?	**YES ☐ NO ☐**	**YES ☐ NO ☐**
4) Within the past **12 months** have you: a) been treated for and/or been diagnosed with internal bleeding; and/or b) been admitted to hospital for a gastrointestinal disease or disorder; and/or c) received treatment (including investigation or testing) for any cancer (except basal cell and squamous cell skin cancer)?	**YES ☐ NO ☐**	**YES ☐ NO ☐**
5) Within the past **12 months** have you been prescribed or taken any of the following: a) Lasix or furosemide for any reason; b) prednisone for any lung condition; c) medications for both diabetes **and** a heart condition (answer **NO** to this question if you are medicated for only one but not both of these conditions. Medication prescribed solely for the control of blood pressure does not count as a medication for a heart condition); d) any form of nitroglycerin for the relief of angina pain (including on an "as needed" basis)?	**YES ☐ NO ☐**	**YES ☐ NO ☐**

STEP 4. COVERAGE OPTIONS (*skip if under age 60 on effective date*)

On the Effective Date indicated on this application, I will be:	I am proceeding as follows:	Applicant 1	Applicant 2
Any Age and purchasing the Basic Plan (Medical Declaration NOT required)	**I select Table 3 Basic Plan rates.** I understand that claims arising from pre-existing medical conditions will **NOT** be covered.	☐	☐
Under Age 55 and purchasing the Enhanced Plan (Medical Declaration NOT required).	**I select Table 1 Enhanced Plan rates.**	☐	☐
Age 55-85 and purchasing the Enhanced Plan. I have answered **NO** to all questions on the Medical Declaration above.	**I select Table 1 Enhanced Plan rates.**	☐	☐
Age 55-85 and I am purchasing the Standard Plan because; i) I have answered **YES** to one or more questions on the Medical Declaration above and am ineligible for the Enhanced Plan, **or**; ii) I do **NOT** want or need coverage for my pre-existing conditions.	**I select Table 2 Standard Plan rates.** I understand that claims arising from pre-existing medical conditions will **NOT** be paid.	☐	☐

STEP 5. COVERAGE DATES

Application Date (mm/dd/yy)	**Time of Issue** am / pm	**Arrival Date** (mm/dd/yy)
Effective Date (mm/dd/yy)	**Expiry Date** (mm/dd/yy)	**No. of Days** (Including Effective & Expiry Dates - Maximum 365 days)

STEP 6. CALCULATE PREMIUM: Aggregate Policy Limit (check ☑ one only)

☐ **$15,000** ☐ **$25,000** ☐ **$50,000** ☐ **$100,000 (including additional $50,000 for injury)** ☐ **$150,000** ☐ **$200,000**

Rated as: (check ☑ one only) ☐ Individual ☐ Companion ☐ Family *The Standard Plan is not available for "Family" and ALL APPLICANTS must select the same Plan.

Premium Calculation	Applicant 1 or Family	Applicant 2	Applicant 3	Applicant 4
Rate per Day (2 times eldest for Family*) or 5% off for companion.	**$**	**$**	**$**	**$**
# of Days	**X**	**X**	**X**	**X**
Deductible Options	☐ $100 (-5%) ☐ $250 (-10%) ☐ $500 (-15%)	☐ $100 (-5%) ☐ $250 (-10%) ☐ $500 (-15%)	☐ $100 (-5%) ☐ $250 (-10%) ☐ $500 (-15%)	☐ $100 (-5%) ☐ $250 (-10%) ☐ $500 (-15%)
(Check one ☑ or leave blank for $0 deductible)	☐ $1000 (-20%) ☐ $5000 (-35%) ☐ $10,000 (-40%)	☐ $1000 (-20%) ☐ $5000 (-35%) ☐ $10,000 (-40%)	☐ $1000 (-20%) ☐ $5000 (-35%) ☐ $10,000 (-40%)	☐ $1000 (-20%) ☐ $5000 (-35%) ☐ $10,000 (-40%)
Total Premium	=	=	=	=

STEP 7. PLEASE READ CAREFULLY before signing (this application must be signed by all applicants or by the sponsor if a Medical Declaration is required)

I/we certify that the information provided on this form is true and accurate, and understand that such information is material to the risk, and constitutes the basis of any coverage offered. I/we fully understand that if any of my/our answers are untrue or incorrect, then coverage offered will be null and void. I/we understand that the Policy contains important terms and conditions of coverage including exclusions and other limitations. I/we understand that Manulife Financial, its agents, third party administrators or its legal representatives may investigate any claim. I/we authorize any hospital, physician or their medical service provider, or any other organization or person that has any records or knowledge of me/us and my/our health to release to third party administrators, and Manulife Financial and its reinsurers, any such information for the purpose of this application, contract and any subsequent claim.

	Applicant/Sponsor Signature	Name of Applicant/Sponsor (please print)	Date (mm/dd/yy)
Applicant 1			
Applicant 2			

STEP 8. RELATIONSHIP TO VISITOR(S) TO CANADA

If you are completing this application on behalf of the Visitor(s) to Canada, please indicate your relationship to the Visitor(s):_____

STEP 9. PAYMENT

Payment type:	☐ **Cheque**	☐ **VISA**	☐ **MasterCard**	☐ **Cash**	
Credit Card Number:					**Expiry Date:** mm/yy
Cardholder Name:			**Cardholder Signature:**		

<u>Important Note</u>: RETURN THIS COMPLETED FORM TO YOUR AGENT. THIS FORM IS <u>NOT</u> AN INSURANCE POLICY; YOUR OFFICIAL 21ST CENTURY TRAVEL INSURANCE POLICY DOCUMENTS, INCLUDING THE "POLICY CONFIRMATION", MUST BE PROVIDED BY YOUR INSURANCE AGENT.

Agent Contact Info:	**Phone #: 604-228-8816**	**Fax #: 604-228-9807**	**Email to: info@david-cummings.com**