Return this form to:
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21st Century Travel Insurance Ltd
Visitor to Canada Application V10

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 for ANY coverage if they:

- are travelling against the advice of a physician;
- have been diagnosed with a terminal illness with less than **2 years** to live;
- have been diagnosed with or received treatment within the past **2 years** for pancreatic, lung, brain or liver cancer;
- have ever been diagnosed with any type of cancer that has spread from one part or organ of the body to another (metastatic cancer);
- have had or are waiting for an organ or bone marrow transplant (excluding corneal transplant);
- have ever been diagnosed with Congestive Heart Failure;
- have been prescribed or used home oxygen in the last **12 months**;
- require kidney dialysis; and/or
- reside in a nursing home, or long-term care facility?

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

Answer the following questions to determine eligibility for the Enhanced Plan if you are age 55 to 85.	**Applicant 1**	**Applicant 2**
1. Within the past **12 months**, and in relation only to the medical conditions listed below, have you: - been newly diagnosed with; - been prescribed any new medication or any *change in medication* for; - had any new or change in treatment, including investigation or testing (do not count regular scheduled maintenance investigations or testing); - been referred to a specialist for; or - been hospitalized or seen in the emergency department of a hospital for: Any of the following medical conditions: a) a heart condition b) a lung condition c) shortness of breath d) chest pain e) stroke, or mini-stroke or TIA (Transient Ischemic Attack)? ***Change in medication*** means the medication dosage, frequency or type has been reduced, increased, stopped and/or new medication(s) has/have been prescribed. Exceptions: the routine adjustment of Coumadin, Warfarin or insulin, as long as they are not newly prescribed or stopped and there has been no change in your medical condition; and, a change from a brand name medication to a generic brand medication of the same dosage.	YES ☐ NO ☐	YES ☐ NO ☐
2. Have you had a heart bypass, heart valve surgery or angioplasty more than **10 years** ago (use the date of the most recent procedure)?	YES ☐ NO ☐	YES ☐ NO ☐
3. Within the past **12 months** have you: a) been treated for and/or been diagnosed with internal bleeding; or b) been admitted to hospital for a gastrointestinal disease or disorder; or c) received treatment including investigation or testing where the results indicate either a new diagnosis of cancer or that cancer has returned or spread (except basal cell and squamous cell skin cancer or breast cancer treated only with hormonal therapy)?	YES ☐ NO ☐	YES ☐ NO ☐
4. Within the past **12 months** have you been prescribed or taken any of the following: a) prednisone for any lung condition; or b) any form of nitroglycerin for the relief of angina pain (including on an "as needed" basis)?	YES ☐ NO ☐	YES ☐ NO ☐
5. Within the past **12 months** have you been prescribed or taken medications for **both** diabetes **and** a heart condition? (Answer **No** if you are medicated for one but not both of these conditions. Medication prescribed solely for the control of blood pressure is not a medication for a heart condition.)	YES ☐ NO ☐	YES ☐ NO ☐

STEP 4. COVERAGE OPTIONS

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 0-85 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: ☐ **VISA** ☐ **MasterCard** ☐ **Send Me Payment Link**		
Credit Card Number:		**Expiry Date:** mm/yy
Cardholder Name:	**Cardholder Signature:**	

Important Note: **RETURN THIS COMPLETED FORM TO YOUR AGENT. THIS FORM IS NOT 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:** agent@david-cummings.com