



INSTRUCTIONS

These instructions have been designed for you to simplify the application process. **Read these instructions in full** before you begin. If you have any questions, please call Medipac for further assistance at **1-888-MEDIPAC** (1-888-633-4722).

Before you begin:

- Review your policy carefully **prior** to your departure; in particular, the “What is Not Covered” and the “General Limitations” sections. Certain exclusions and/or other limitations in benefits are applicable to your coverage.
- The policy contains stability period requirements which are applicable to any **new** and/or **pre-existing** medical conditions. If you do not meet the requirements of the stability period clauses, or you are ineligible for coverage, or have a change in health after your date of application and prior to your effective date of insurance, it is important that you call us; coverage may be available through our Individual Underwritten Insurance.
- If you are unclear about **any** of your medical conditions or medications, consult your doctor.

NOTE: Trips in excess of 183 days are available to residents of **all** provinces and territories **except** QC, PEI and NU.

Completing the Application:

- The application must be filled out in full and in **pen**.
- Your emergency contact should not be the person with whom you are travelling.
- All of the medical questions in sections A, C and D must be answered unless you are under the age of 56 and travelling for less than 41 days. Changes **must** be initialled by the applicant.
- An application cannot be processed without specific departure and return dates. If you are unsure of your dates, select the dates and trip length that are closest to your estimated travel time period. When you have finalized your travel plans, call us before your departure date

for your **free** policy change (*if your trip length changes, a premium adjustment may be required*).

- Your application must be **signed and dated** by both applicants (if applicable). Be sure that you **read and understand** section H. DECLARATION/AUTHORIZATION.

Skipping any of the above steps will require correction and will delay processing of your application.

Important reminders:

- You **must** have a policy number before you leave for your trip.
- If you have **any change in health** after the date you completed your application and prior to your effective date of insurance, you **must** call Medipac.
- Prior to seeking medical attention **you must call Medipac Assist**. Failure to call will result in benefits being limited (*see policy wording included*). If you are experiencing a medical emergency, call 911 first. As with all travel insurance plans, in the event of a claim, your medical records **will** be reviewed.
- Change in plans? If you are leaving before or after your original effective date you **must** notify Medipac in advance to change your dates, or your coverage will be limited.
- Staying longer than expected? Call Medipac for an extension of coverage. Extensions **must** be applied for prior to your expiry date. (*see policy extension wording included*).
- Need to cancel or coming home early? *See policy refund wording included*.



CHECKLIST



Before you submit your application, ensure that:

- All medical questions have been answered and any changes made to the application have been initialled by the individual applying for insurance.
- You have indicated your departure and return dates, trip length and deductible.
- Each applicant has signed and dated section H with the date the application was actually signed.
- Your payment is included. *Full payment must be received prior to departure, or your policy will not be valid. NSF's will be charged \$25.*

To Pay In Full:

- Include a cheque payable to Medipac Travel Insurance or complete the credit card information in section I.

To Pay in 2 Equal Instalments (only available with payment by cheque):

- To take advantage of the 2-instalment option, include one cheque marked VOID (post-dated cheques are not required).
- The first of your 2 payments will be collected on the date your application is processed. The balance of your premium will be collected one month following that date.



If you are travelling for less than 41 days and you are under the age of 56, you do not have to complete sections A, C and D of this application.

If you are uncertain of your answer to any of the medical questions, consult your doctor.

A. ELIGIBILITY		APPLICANT 1		APPLICANT 2	
		YES	NO	YES	NO
1	Have you been diagnosed as having a terminal illness, been advised by a physician not to travel or do you have HIV, AIDS or AIDS-related complex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Have you been diagnosed with pulmonary fibrosis or interstitial lung disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Have you EVER had an organ or bone marrow transplant (excluding cornea or skin graft) or a blood disorder for which you have received stem cell treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	During the 5 YEARS prior to the date of this application, have you been treated for, taken or been prescribed medication for, or been diagnosed with lung cancer, metastatic cancer or two (2) or more cancers (excluding basal cell and squamous cell skin cancer)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Do you HAVE a cardiac condition with an ejection fraction of LESS THAN 40% or a ventricular function grade of 3 or 4?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Do you HAVE moderately severe or severe cardiac valve stenosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Do you HAVE an aneurysm or dilated artery greater than 4.5 cm in size (diameter or width) which remains surgically untreated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	During the 6 MONTHS prior to the date of this application, have you:				
	a undergone chemotherapy, immunotherapy or targeted therapy for cancer or malignant tumour(s)?	8a	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b had surgery or stenting on ANY artery or cardiac pacemaker implant surgery?	8b	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	During the 12 MONTHS prior to the date of this application have you:				
	a had cardiac ablation, cardiac defibrillator implant surgery, coronary angioplasty and/or stent, coronary bypass surgery, cardiac valve replacement or repair, had a heart attack or had an episode of congestive heart failure?	9a	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b had a stroke, a transient ischemic attack (TIA) or a ministroke?	9b	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c had ANY chronic lung disease (including emphysema, chronic obstructive pulmonary disease [COPD], chronic bronchitis, reactive airway disease or asthma) which caused you to be hospitalized for more than 24 consecutive hours, or for which you have taken or been prescribed prednisone or Solu-Medrol?	9c	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d taken or been prescribed home oxygen for any reason?	9d	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e been hospitalized with COVID-19 in an intensive care unit (ICU)?	9e	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	f taken or been prescribed insulin or two (2) or more medications for diabetes AND medication for a heart condition? <i>If medication is taken or prescribed for only one condition, answer "No" to this question.</i> The term "medication" includes nitroglycerin in any form.	9f	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



IF YOU ANSWERED YES TO ANY QUESTION ABOVE, YOU ARE NOT ELIGIBLE.
Call 1-877-888-5259 for our Individual Underwritten Insurance.



IF YOU ANSWERED NO TO ALL QUESTIONS ABOVE, YOU ARE ELIGIBLE
to purchase this plan. Please complete the application.

B. PERSONAL INFORMATION				Please Print			
APPLICANT 1				APPLICANT 2			
Given Name and Surname:				Given Name and Surname:			
Date of Birth: Day: _____ Month: _____ Year: _____ Male <input type="checkbox"/> Female <input type="checkbox"/>				Date of Birth: Day: _____ Month: _____ Year: _____ Male <input type="checkbox"/> Female <input type="checkbox"/>			
Have you received at least one dose of a COVID-19 vaccine? Yes <input type="checkbox"/> No <input type="checkbox"/>				Have you received at least one dose of a COVID-19 vaccine? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Have you smoked cigarettes in the 2 years prior to the date of this application? Yes <input type="checkbox"/> No <input type="checkbox"/>				Have you smoked cigarettes in the 2 years prior to the date of this application? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Doctor's Name:		Phone: ()		Doctor's Name:		Phone: ()	
Specialist's Name (if any):		Phone: ()		Specialist's Name (if any):		Phone: ()	
Specialty Type:				Specialty Type:			
Emergency Contact Person not travelling with you:		Phone: ()		Emergency Contact Person not travelling with you:		Phone: ()	
CANADIAN ADDRESS (Both Applicants)				OUT-OF-COUNTRY ADDRESS (Both Applicants, if applicable)			
Street Name & Number:		Apt # or Lot #:		Street Name & Number:		Apt # or Lot #:	
City:	Province:	Postal Code:		City:	State:	Zip Code:	
E-mail:				E-mail:			
Phone: ()		Cell: ()		Phone: ()		Cell: ()	
Please mail my insurance policy to my: <input type="checkbox"/> Canadian Address <input type="checkbox"/> Out-of-Country Address							

C. RATE QUALIFICATION - PART 1			APPLICANT 1 YES NO	APPLICANT 2 YES NO
1	Have you EVER had congestive heart failure or heart surgery of ANY kind (including cardiac ablation, cardiac pacemaker/defibrillator implant, coronary angioplasty and/or stent, coronary bypass surgery, cardiac valve replacement or repair)?	1	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	During the 5 YEARS prior to the date of this application, have you been treated for, taken or been prescribed medication for, or been diagnosed with:			
	a narrowing or blockage of ANY artery (including pulmonary embolism [PE], peripheral vascular disease [PVD] or carotid stenosis), an aneurysm, pulmonary hypertension, a heart attack, ANY heart condition (including atrial fibrillation or irregular heart beat) or angina? The term "medication" includes nitroglycerin in any form.	2a	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	b chronic lung disease (including emphysema, chronic obstructive pulmonary disease [COPD] or chronic bronchitis)?	2b	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	c a stroke, a transient ischemic attack (TIA), a ministroke or amaurosis fugax (excluding treatment with aspirin)?	2c	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3	During the 3 YEARS prior to the date of this application, have you been treated for, taken or been prescribed medication for, or been diagnosed with chronic bowel disease or disorder (including colitis, Crohn's disease, diverticulitis or irritable bowel syndrome), pancreatitis or gastrointestinal bleeding?	3	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
4	During the 2 YEARS prior to the date of this application, have you taken or been prescribed two (2) or more inhalers (including a rescue inhaler)?	4	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
5	During the 12 MONTHS prior to the date of this application, have you been treated for, taken or been prescribed medication for, or been diagnosed with cancer or malignant tumour(s) (excluding basal cell and squamous cell skin cancer)? The term "medication" excludes tamoxifen and ANY other hormone treatment.	5	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
6	During the 3 MONTHS prior to the date of this application, have you taken or been prescribed:			
	a corticosteroids (including prednisone and Solu-Medrol) for more than 15 days (excluding inhalers, topical medications and eye drops)?	6a	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	b a total of 3 or more medications for diabetes (including glucose intolerance), hypertension (high blood pressure) or both? The term "medication" includes diuretics (water pills).	6b	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
7	Have you been diagnosed with Lou Gehrig's disease (ALS), muscular dystrophy, myasthenia gravis, cerebral palsy, multiple sclerosis or dementia (including Alzheimer's disease)?	7	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
8	Do you HAVE reduced kidney function with an eGFR of less than 45 or cirrhosis of the liver?	8	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
9	Do you HAVE diabetes requiring insulin?	9	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

D. RATE QUALIFICATION - PART 2			APPLICANT 1 YES NO	APPLICANT 2 YES NO
1	Have you EVER had narrowing or blockage of ANY artery (including pulmonary embolism [PE], peripheral vascular disease [PVD] or carotid stenosis), an aneurysm, pulmonary hypertension, a heart attack, ANY heart condition (including atrial fibrillation or irregular heart beat) or angina?	1	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	Have you EVER had a stroke, a transient ischemic attack (TIA) or a ministroke?	2	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3	Do you HAVE diabetes (including glucose intolerance) requiring medication?	3	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
4	During the 2 YEARS prior to the date of this application, have you been treated for, taken or been prescribed medication for, or been diagnosed with:			
	a a blood disorder by an Internist or a Hematologist?	4a	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	b epilepsy or any other seizure disorder (including an untreated episode)?	4b	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	c Parkinson's disease?	4c	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	d transient global amnesia?	4d	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
5	During the 12 MONTHS prior to the date of this application, have you had a fainting spell or a syncopal episode?	5	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
6	During the 3 MONTHS prior to the date of this application, have you taken or been prescribed:			
	a anticoagulants (blood thinners) or antiplatelets (excluding aspirin)?	6a	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	b Lasix or furosemide?	6b	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	c any immunosuppressive drugs (excluding methotrexate)?	6c	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

WHICH PLAN DO YOU QUALIFY FOR?

If you answered NO to ALL of the questions in section C and D,	If you answered NO to ALL of the questions in section C but YES to ANY of the questions in section D,	If you answered YES to ANY of the questions in section C,
YOU QUALIFY FOR THE PREFERRED PLUS PLAN	YOU QUALIFY FOR THE PREFERRED PLAN	YOU QUALIFY FOR THE STANDARD PLAN



NEED HELP? Call 1-888-MEDIPAC
 1-888-633-4722 • (416) 441-7070 in the GTA • Fax # (416) 441-7030
 Medipac Travel Insurance, 180 Lesmill Road, Toronto, ON M3B 2T5 • www.medipac.com

Underwritten by
Old Republic Insurance Company of Canada
 Administered by Medipac International Inc.

E. TRAVEL INFORMATION

If you are taking multiple trips, provide details on a separate piece of paper.

APPLICANT 1

SINGLE TRIP DETAILS

APPLICANT 2

Must be completed even if topping up.

Date of Departure: Day: _____ Month: _____ Year: _____

Same as applicant 1
Date of Departure: Day: _____ Month: _____ Year: _____

Scheduled Return Date: Day: _____ Month: _____ Year: _____

Scheduled Return Date: Day: _____ Month: _____ Year: _____

OTHER INSURANCE COVERAGE

If you have other Insurance with similar out-of-country benefits, provide details. Must be completed if topping up, or applying for Federal Superannuate Credit.

I am a **Superannuate** and I request that my policy be issued with a deductible of \$500,000 CAD for the first 40 days of my trip.

I am a **Superannuate** and I request that my policy be issued with a deductible of \$500,000 CAD for the first 40 days of my trip.

I am **topping up** my other insurance and request that my Medipac Effective Date be: Day: _____ Month: _____ Year: _____

I am **topping up** my other insurance and request that my Medipac Effective Date be: Day: _____ Month: _____ Year: _____

Name of Plan: _____ Number of days covered: _____

Name of Plan: _____ Number of days covered: _____

Insurance Company: _____ Single Coverage Family Coverage

Insurance Company: _____ Single Coverage Family Coverage

Policy #: _____ Certificate #: _____

Policy #: _____ Certificate #: _____

NUMBER OF DAYS APPLIED FOR (see rate tables for trip lengths)

3	6	9	12	15	18	21	24	27	30	33	36	40	50	60	66	75
82	90	96	105	112	120	126	135	142	150	156	165	175	183	190	200	212

3	6	9	12	15	18	21	24	27	30	33	36	40	50	60	66	75
82	90	96	105	112	120	126	135	142	150	156	165	175	183	190	200	212

ANNUAL ADD-ON

I am purchasing the **Annual Add-on:** 23-day 33-day

I am purchasing the **Annual Add-on:** 23-day 33-day

A. to start on my Effective Date of Insurance, **OR**

A. to start on my Effective Date of Insurance, **OR**

B. to start on Day: _____ Month: _____ Year: _____

B. to start on Day: _____ Month: _____ Year: _____

For Option B, this date must be between the date your application is processed and your Effective Date of Insurance. You must buy a minimum 22-24 day trip to purchase the 23-day Annual Add-on or a minimum 31-33 day trip to purchase the 33-day Annual Add-on.

MedipacMAX / MedipacPLUS

Add MedipacMAX Add MedipacPLUS

Add MedipacMAX Add MedipacPLUS

F. PREMIUM CALCULATION

Rate Category:	<input type="checkbox"/> Preferred PLUS	<input type="checkbox"/> Preferred	<input type="checkbox"/> Standard	Rate Category:	<input type="checkbox"/> Preferred PLUS	<input type="checkbox"/> Preferred	<input type="checkbox"/> Standard				
Select USD Deductible:	<input type="checkbox"/> \$0	<input type="checkbox"/> \$99	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000	Select USD Deductible:	<input type="checkbox"/> \$0	<input type="checkbox"/> \$99	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000
Age at Departure:				Age at Departure:							
Single Trip Rate for Applicant 1:				Single Trip Rate for Applicant 2:							
SUBTRACT Total discount (including 5% COVID-19 vaccine discount): (_____) %	-			SUBTRACT Total discount (including 5% COVID-19 vaccine discount): (_____) %	-						
ADD Annual Add-on Rate (if applicable):	+			ADD Annual Add-on Rate (if applicable):	+						
Rate Subtotal:	=			Rate Subtotal:	=						
ADD 10% if taking a \$0 Deductible:	+			ADD 10% if taking a \$0 Deductible:	+						
Subtotal:	=			Subtotal:	=						
ADD 20% if you have smoked cigarettes in the 2 years prior to the date of this application:	+			ADD 20% if you have smoked cigarettes in the 2 years prior to the date of this application:	+						
SUBTRACT Federal Superannuate Credit (if applicable):	-			SUBTRACT Federal Superannuate Credit (if applicable):	-						
ADD \$147 for MedipacMAX (recommended) or \$59 for MedipacPLUS:	+			ADD \$147 for MedipacMAX (recommended) or \$59 for MedipacPLUS:	+						
Total Premium for Applicant 1:	=			Total Premium for Applicant 2:	=						

G. PAYMENT OPTION

Premiums are in Canadian dollars

OPTION 1: Pay in Full.

OPTION 2: Pay in 2 Equal Instalments. See instructions for details.

Make your cheque payable to Medipac Travel Insurance or fill out the credit card information in section I.

50% of your premium will be collected on the date your application is processed; the balance will be collected one month following that date. Include a VOID cheque with your application.

