**IMPORTANT: Your agent cannot assist you in answering any of the questions on this form.
If you are unsure as to your answers, please consult your physician.**

TIPS Insurance Eligibility Questionnaire

To be completed by anyone:

a) wishing to purchase coverage for a trip with a cost greater than **$15,000**; or
b) **over 69 years of age** on their departure date travelling more than **16 days** and wishing to purchase the **All Inclusive Worldwide Plan** ; or
c) **over 49 years of age and under 90 years of age** on their departure date wishing to purchase the **TIPS Seniors Emergency Medical Plan.**

Part 1:

APPLICANT NAME: ____ DATE OF APPLICATION: (mm/dd/yy) ____/_____/______

DATE OF BIRTH: (mm/dd/yy) ____/_____/______ DEPARTURE DATE: _____/_____/______ EFFECTIVE DATE (For Top Ups) _____/_____/______

RETURN/TERMINATION DATE _____/_____/_____ CANADIAN TELEPHONE NUMBER ______________________________

Part 2:

1. Have you been diagnosed with a terminal illness or are you currently under advisement from a physician not to travel? .... Yes ___ No ___
2. Is your most recent coronary by-pass surgery prior to January 1, 2000? (If you have not had a coronary by-pass surgery, please answer "No".) .... Yes ___ No ___
3. In the **3 years** prior to your departure date, have you:
   a. been diagnosed with or received **Treatment** (see definition below) for 2 or more conditions in Medical Conditions Table A (below)?.................... Yes ___ No ___
   b. had 2 or more heart attacks, strokes or mini-strokes (TIA)? .... Yes ___ No ___
   c. had 2 or more heart surgeries (including angioplasty and stent)? .... Yes ___ No ___
   d. had congestive heart failure? .... Yes ___ No ___
   e. had kidney failure? .... Yes ___ No ___
   f. had metastatic cancer?.................... Yes ___ No ___
4. In the **12 months** prior to your departure date, have you:
   a. been hospitalized for any condition(s) in Medical Conditions Table A or Table B (below)? .... Yes ___ No ___
   b. had any lung condition requiring home oxygen or prednisone tablets (except one time usage of prednisone for up to 14 days in duration)? .... Yes ___ No ___
   c. resided in a retirement home, nursing home, assisted living home, convalescent home, hospice or rehabilitation centre that assists you daily with your mobility or medications (do not include a one-time temporary stay at a rehabilitation centre of no more than 6 weeks during the 12 months prior to Your departure date) ? .... Yes ___ No ___
   d. had chemotherapy, radiation therapy or any surgery for cancer (excluding the removal of skin lesions other than malignant melanoma)? .... Yes ___ No ___

Treat, **Treated** or **Treatment -** means a medical, therapeutic or diagnostic procedure prescribed, performed or recommended by a Physician, including but not limited to prescribed medication, investigative testing and surgery. Do not count aspirin, acetaminophen or ibuprofen as **Treatment**.

If you answered <u>**YES**</u> to any of questions **1 to 4** in **Part 2** above, then you <u>**are not eligible**</u> to purchase this insurance.

If you answered <u>**No**</u> to all questions **1 to 4** in **Part 2** above then you <u>**are eligible**</u> to purchase this insurance. Please proceed as follows:

a) If your trip cost is greater than **$15,000**, please complete and sign **Part 5** of this document.
b) If you are **over 69 years of age** travelling more than **16 days** and wishing to purchase the **All Inclusive Worldwide Plan**, please complete and sign **Part 3** and **Part 5** of this document.
c) If you are wishing to purchase the **TIPS Seniors Emergency Medical Plan,** please complete and sign **Part 3, Part 4** and **Part 5** of this document.

MEDICAL CONDITIONS TABLES

<u>Table A</u>

Please ✓ each condition you have been diagnosed with or have received **Treatment** (see definition above) in the **3 years** prior to your Departure Date. **(Note: 2 conditions ✓ in Table A means you are <u>not eligible</u> to purchase this insurance.)**

- ☐ Heart attack, angina or coronary artery disease
- ☐ Valvular heart disease, abnormal heartbeat, arrhythmia or use of a pacemaker
- ☐ Any lung or respiratory condition requiring the use of prescription medication (including inhalers) prescribed for use on at least a <u>daily basis</u>
- ☐ Diabetes requiring insulin
- ☐ Stroke or mini-stroke (TIA)
- ☐ Aneurysm
- ☐ Blood clots
- ☐ Peripheral vascular disease
- ☐ Alzheimer's or dementia

<u>Table B</u>

Please ✓ each condition you have been diagnosed with or have received **Treatment** (see definition above) in the **2 years** prior to your Departure Date

- ☐ Any lung or respiratory condition requiring the use of prescription medication (including inhalers) prescribed for use on an <u>as needed basis</u>
- ☐ Diabetes requiring medication other than insulin
- ☐ Cancer (excluding the removal of skin lesions other than malignant melanoma)
- ☐ Diverticulitis
- ☐ Gastro-intestinal bleed
- ☐ Bowel obstruction
- ☐ Ulcerative colitis or Crohn's disease
- ☐ Liver condition
- ☐ Parkinson's
- ☐ Any seizure disorder
- ☐ Kidney stones
- ☐ Gallbladder Disease and/or gall stones

Part 3:

Health Score Calculation:

a) Score **3 points** for the condition ✓ in Medical Conditions Table A (previous page) for which you have been diagnosed with or have received **Treatment** (see definition previous page) in the **3 years** prior to your departure date. **Note: 2 conditions ✓ in Table A means you are not eligible to purchase this insurance**.

b) Score **1 point** for each condition ✓in Medical Conditions Table B (previous page) for which you have been diagnosed with or have received **Treatment** (see definition previous page) in the **2 years** prior to your departure date.

TOTAL HEALTH SCORE TABLE A: _____

TOTAL HEALTH SCORE TABLE B: _____

TOTAL HEALTH SCORE: _____

Health Score	Plan Eligible
0	0
1	1
2	2
3	3
4	4
5 or More	5

Part 4:

CANADIAN ADDRESS: ____________________

EMAIL ADDRESS ____________________

CANADIAN PHYSICIAN NAME & TELEPHONE: ____________________

RETURN/TERMINATION DATE (Must be before Sept. 30, 2015 for Single Trip Plans) ____/____/_____ NUMBER DAYS REQUIRED: ________

PREMIUM CALCULATION:

A. Do you wish to purchase an Annual Plan?........ Yes _____ No _____

15 DAY ANNUAL PLAN? _____ 30 DAY ANNUAL PLAN? _____

B. Do you wish to purchase a Single Trip Plan?........ Yes _____ No _____

C. Have you been prescribed (whether taking or not) any medication for High Blood Pressure? (10% Surcharge) .... Yes _____ No _____

D. Have you used any tobacco products since January 1, 2009? (20% Surcharge) .... Yes _____ No _____

E. Do you require the OPTIONAL 3 MONTH STABILITY UPGRADE? (10% Surcharge) .... Yes _____ No _____
(For Plans 2, 3, 4 and 5, can change pre-ex stability period from 12 months to 3 months)

F. Do you wish to CHANGE FROM A $0 DEDUCTIBLE? .... Yes _____ No _____

$500 Deductible Subtract	10% ___	$5,000 Deductible Subtract	35% ___
$1,000 Deductible Subtract	15% ___	$10,000 Deductible Subtract	45% ___

Part 5:

DECLARATION/AUTHORIZATION

You must read the following. Only signed applications are acceptable.

I declare that on my departure date I will be covered under the government health insurance plan in my Canadian province/territory of residence.

I understand that the insurance applied for will not become effective unless Reliable Life Insurance Company receives the full premium and a signed copy of this application. I understand that only treatment for a medical emergency is covered under this insurance.

I understand that I should read my policy upon receipt prior to travel.

I declare that I meet the eligibility requirements of the TIPS insurance plan purchased. Where I was unsure of my medical history as it relates to these requirements, I have verified it with my physician and have not sought assistance from any non-medical personnel. I agree that if I do not meet both the required eligibility requirements for the plan I have purchased or if any material misrepresentation or evasion is contained herein, then Reliable Life Insurance Company will void my policy and no coverage will be provided.

If, prior to my departure date my medical condition changes or I am not eligible for the plan purchased, I will notify Reliable Life Insurance Company. I agree that in the event that I am ineligible or that a claim is found to be invalid or benefits are reduced in accordance with any policy provision, Reliable Life Insurance Company has the right to collect from me the amount that it has paid on my behalf to medical providers or other parties.

I authorize and consent to Reliable Life Insurance Company to collect, use and disclose to third parties any personal information for the purpose of determining my eligibility for coverage under the policy, assessing insurance risks, managing and adjudicating claims and negotiating or settling payments to third parties. This information may also be shared with third parties, such as other insurance companies, health organizations and government health insurance plans to adjudicate and process any claim submitted by me or on my behalf.

I authorize and direct any physician, health care practitioner, hospital, or other medical care facility, pharmacy, The Ministry of Health or any other person who has attended or examined me or who has knowledge or records of me or my health, to furnish Reliable Life Insurance Company, or its agents, any or all information with respect to any illness, injury, medical history, consultations, medicines or Treatment and copies of all hospital and/or medical records. I understand and agree that information relating to the administration of benefits under this plan may be provided to third parties to whom access has been granted or those authorized by law.

I authorize and direct any other insurance plan under which I am covered to disclose personal information as may be necessary or to make payment in respect of my claim to Reliable Life Insurance Company directly.

Only you (the APPLICANT) can complete and sign this application.

____________________ ____________________

APPLICANT SIGNATURE DATE

This application will not be accepted without full completion, proper signature and full payment.

A copy of this completed questionnaire should be retained for your records.

The policy contains exclusions, conditions and limitations. Upon receipt, please read your policy thoroughly.
It is important that you understand the coverage described in the policy and are satisfied with it.
Within 10 days of receipt of your policy and prior to departure, you may cancel your policy for any reason and obtain a full refund.