Priority Healthcare Insurance

Application
Age 39 or under

RSA

For Head Office Use Only

34 01 APP ECA 1215 000_REV0219

Important Instructions

All sections must be completed in full. Incomplete forms will be returned to sender for completion and re-submission.

Please note that a copy of the original Application will be accepted as long as the method of transmission complies with applicable law.

Together with the Application, the Priority Healthcare Insurance Authorization Form is a mandatory requirement to be submitted by the applicant or, in the case of a minor, on behalf of the applicant. Please attach the Authorization Form to your Application.

If more space is required, please attach additional pages, indicating you have done so in the appropriate section.

Applications should be submitted to RSA Travel Insurance (hereafter "RSA") at the following coordinates:

RSA
Attn: Priority Healthcare Insurance Applications
650 - 2665 King Ouest
Sherbrooke, QC J1L 2G5
Fax: 1-888-797-4397 (toll free) or 819-566-1084

Request for Policy Change (complete Sections 2, 6 and 8)

An insured person with an existing policy may request a policy change by **completing sections 2, 6 and 8** of this Application. The request must be submitted to the Insurer 60 days prior to policy renewal. Any health changes since the inception date of the existing policy may affect rating and/or require additional exclusions in coverage. If such is the case, the insured person may choose to maintain the original medical underwriting evaluation.

Policy No.: _____

Change request:

☐ Smoker to non-smoker status (must be smoke free for a period of 12 months or more on the date of the request for policy change)

☐ Review of medical underwriting exclusion(s) and/or rating factor

The completed and signed Application and Evidence of Insurability are essential to the appraisal of the risk by the Insurer and are the basis of and form part of the contract. The Insurer may exercise its right to void any policy in the event of non-disclosure or misrepresentation in the Evidence of Insurability provided with this request for policy change.

Section 1 – Important Notice about Your Personal Information

By submitting this application you agree that Royal & Sun Alliance Insurance Company of Canada ("we", "us") may collect, use and disclose your Personal Information (including to and from your broker, our affiliates and service providers and organizations that may have referred you to us, and professional associations of which you may be a member) for purposes of quoting a premium, policy administration, improving customer experience, administering referral arrangements, and for other lawful purposes described in our Protecting Customer Privacy document. For a copy of this document please see **www.rsatravelinsurance.com/privacy**.

Section 2 – Applicant Information

PLEASE PRINT:

Last Name | First Name & Initial

Street Address | Apt. No.

P.O. Box, R.R.

City | Province | Postal Code

Telephone | Mobile

Email

Occupation

Gender: ❑ Male ❑ Female Date of Birth: D | M | Y Language Preference: ❑ English ❑ French

Section 3 – Employer Information (if applicable)

If you are completing this Application as part of a submission for payment of premium by an employer on your behalf, please complete the following information:

Plan Sponsor/Employer Name

Plan Administrator (if applicable – please print name)

Street Address

Suite No.

P.O. Box, R.R.

City

Province

Postal Code

Business Telephone

Section 4 – Common Renewal Date

Subject to the Insurer's written approval, a common Renewal Date may be granted for employer sponsored policies or for an Applicant who is a member of a family that is in the process of applying for, or already insured under, a Priority Healthcare Insurance policy. The policy term shall not exceed 12 consecutive months.

Are you requesting a common Renewal Date? ❑ Yes ❑ No

If yes, for an employer sponsored policy, indicate the common Renewal Date requested: D M

Note: Where the Applicant is a member of a family, the common Renewal Date will be the Policy Renewal Date of the first family member insured.

Section 5 – Other Insurance

Do you have other medical coverage? If so, please complete below:

Insurance Company

Group Number/Policy Number

Certificate Number

Section 6 – Evidence of Insurability

The following information is admitted as evidence of your insurability and as a condition of the medical underwriting process.*

Further medical information may be required; however, that will be evaluated once the initial data is complete and has been reviewed by the Insurer.

If coverage is requested for an Applicant who is a minor, all questions and requests for additional information must be directed to the parent or Legal guardian on behalf of the Applicant, as a condition to the medical underwriting process.

All Applicants who have reached the age of majority must submit their own Evidence of Insurability.

In order to determine age of majority with respect to the Evidence of Insurability, please refer to the following chart:

Age of Majority by Province or Territory	
Age	Province or Territory
18	AB, MB, ON, PE, QC, SK
19	BC, NB, NL, NS, NT, NV, YT

*** Note:** All Applicants must submit to the underwriting process and provide written authorization that they understand and willingly consent to and participate in this process, as outlined in the Authorization From to be submitted with this Application.

Section 6 – Evidence of Insurability (continued)

Please complete the following contact information:

PLEASE PRINT:

Name of Parent, or Legal Guardian to be contacted (if applicable) | Telephone Number

Physician Contact Information

Name of Family Physician | Telephone Number | Fax Number

Street Address | Suite Number

P.O. Box, R.R.

City | Province | Postal Code

Any Other Physician(s) ☐ **Yes** ☐ **No**
If yes:

Name of Physician | Speciality | Telephone Number | Fax Number

Name of Physician | Speciality | Telephone Number | Fax Number

IMPORTANT: Provide details to any "Yes" answer(s) on page 5. If there are any "Yes" responses, the Insurer will request an Attending Physician Statement.

Height: _____ **Weight:** _____ **Waist size:** _____ **Waist size at umbilicus (navel):** _____

1. When was your last complete regular check-up?
   Regular check-up means any standard or customary medical examination unrelated to any specific medical condition and is carried out for the purpose of screening, health monitoring or preventive care and may include routine medical tests and investigations.

   a) Date: _____

   b) Results: _____

2. Have you ever had an application for health or life insurance declined, cancelled or modified in any way? If yes: ☐ Yes ☐ No
   a) Type of insurance: _____
   b) Reason: _____
   c) Year: _____
3. Do you presently have a medical condition, or are you presently receiving treatment, under prescription and/or taking medication? ☐ Yes ☐ No
4. Do you have any physical or mental impairment, congenital or otherwise? ☐ Yes ☐ No
5. Are you presently on a waiting list for investigations, a surgical procedure or any treatment? ☐ Yes ☐ No

Section 6 – Evidence of Insurability (continued)

Have you ever had any diagnosis, consultation, treatment, been prescribed and/or taken medication, been hospitalized for any of the following medical conditions:

6.	Heart condition?	❑ Yes	❑ No
7.	Stroke (CVA), mini-stroke (TIA), epilepsy, headaches or other nervous system disorder?	❑ Yes	❑ No
8.	Hypertension? If yes, provide blood pressure levels: Date: _____ Systolic: _____ Diastolic: _____	❑ Yes	❑ No
9.	Hyperlipidemia? If yes, provide lipid panel levels: Date: _____ Total cholesterol: _____ Triglyceride: _____ HDL-C: _____ LDL-C: _____	❑ Yes	❑ No
10.	Any vascular conditions, i.e. involving arteries (such as peripheral vascular disease or aneurysm) or veins (such as phlebitis or thrombosis)?	❑ Yes	❑ No
11.	Anemia or blood disorder?	❑ Yes	❑ No
12.	HIV (Human Immunodeficiency Virus), any HIV related illness, or AIDS (Acquired Immune Deficiency Syndrome)?	❑ Yes	❑ No
13.	Diabetes?	❑ Yes	❑ No
14.	Thyroid or other glandular conditions?	❑ Yes	❑ No
15.	Cysts, tumors or cancer?	❑ Yes	❑ No
16.	Gastro-intestinal, liver, gallbladder, spleen or pancreas problems?	❑ Yes	❑ No
17.	Kidney, bladder or other genito-urinary problems?	❑ Yes	❑ No
18.	Asthma, chronic bronchitis, emphysema or other disease of the lung or respiratory system?	❑ Yes	❑ No
19.	Back, neck, hip, knee or other joint disorder (i.e., arthritis, rheumatism, etc.)?	❑ Yes	❑ No
20.	Eyes, ears, nose, throat or jaw problems?	❑ Yes	❑ No
21.	Skin problems or conditions?	❑ Yes	❑ No
22.	Abnormal findings/studies?	❑ Yes	❑ No

Within the past 10 years, for any reason not already disclosed, have you:

23.	Been hospitalized or advised to be hospitalized?	❑ Yes	❑ No
24.	Had surgery or been advised to have surgery?	❑ Yes	❑ No
25.	Had any injury, illness, medical attention, medical advice or treatment?	❑ Yes	❑ No
26.	Been advised to have any test which was not done?	❑ Yes	❑ No

Smoking, drinking and drug use:

27.	Have you consumed tobacco products, in any form, in the past 12 months (cigarettes, pipe, cigars, cigarillos, chewing tobacco)? If yes: a) Type of product: b) Amount used: _____ /day _____ /week _____ /month _____ /year c) Date last used: d) End date (if applicable):	❑ Yes	❑ No
28.	In the 5 years prior to the date of Application, have you consumed alcoholic beverages? If no, go to question 29. If yes, what is your average consumption for: _____ Beer (bottles/cans) / ❑ day ❑ week ❑ month _____ Wine (glasses) / ❑ day ❑ week ❑ month _____ Liquor (oz/ml) / ❑ day ❑ week ❑ month	❑ Yes	❑ No

Section 6 – Evidence of Insurability (continued)

29.	Have you ever experienced a problem with alcohol consumption? If yes,	❑ Yes ❑ No
	a) Have you ever reduced your alcohol consumption?	❑ Yes ❑ No
	b) Have you ever been treated or received advice for alcohol use?	❑ Yes ❑ No
	c) Are you or have you been a member of a support group related to alcohol consumption?	❑ Yes ❑ No
	d) If treated, have you ever had a relapse?	❑ Yes ❑ No
30.	In the 5 years prior to the date of Application, have you used:	
	a) Marijuana?	❑ Yes ❑ No
	b) Any non-prescribed narcotic (e.g. Codeine, Heroin, Opium, Demerol)?	❑ Yes ❑ No
	c) Barbiturates (e.g. goof balls, downers, barbs, candy, phenobarbital, seconal)?	❑ Yes ❑ No
	d) Stimulants (cocaine, crack, amphetamines, antidepressants, Benzedrine, Dexedrine, methedrine, ecstasy) or derivatives?	❑ Yes ❑ No
	e) Hallucinogens (mescaline, LSD, PCP, DMT, STP, glue)?	❑ Yes ❑ No
	f) Tranquilizers (Valium, Librium, Benzodiazepine) or their derivatives?	❑ Yes ❑ No
	g) Steroids or anabolic steroids?	❑ Yes ❑ No
	h) Any similar drug?	❑ Yes ❑ No

Please list below all medications currently prescribed to you or taken by you. In addition, please list any other medical conditions.

Please provide details to "Yes" answers. If more space is required, please attach a separate sheet.

Question	Illness/Impairment (Including all medications)	Date Diagnosed or Treated	Please provide details
#			
#			
#			
#			
#			
#			
#			
#			
#			
#			

Section 6 – Evidence of Insurability (continued)

Family Medical History

Father - Name: _____

❑ Living ❑ Deceased Age (if deceased, age at time of death): _____

Medical Conditions (check if applicable):

❑ Heart Condition Specify: _____ Age at diagnosis: _____

❑ Diabetes Age at diagnosis: _____

❑ Hypertension Age at diagnosis: _____

❑ Cancer Specify: _____ Age at diagnosis: _____

❑ Any Hereditary Conditions: Condition(s): _____

Mother - Name: _____

❑ Living ❑ Deceased Age (if deceased, age at time of death): _____

Medical Conditions (check if applicable):

❑ Heart Condition Specify: _____ Age at diagnosis: _____

❑ Diabetes Age at diagnosis: _____

❑ Hypertension Age at diagnosis: _____

❑ Cancer Specify: _____ Age at diagnosis: _____

❑ Any Hereditary Conditions: Condition(s): _____

Sibling #1 - Name: _____ ❑ Male ❑ Female

❑ Living ❑ Deceased Age (if deceased, age at time of death): _____

Medical Conditions (check if applicable):

❑ Heart Condition Specify: _____ Age at diagnosis: _____

❑ Diabetes Age at diagnosis: _____

❑ Hypertension Age at diagnosis: _____

❑ Cancer Specify: _____ Age at diagnosis: _____

❑ Any Hereditary Conditions: Condition(s): _____

Sibling #2 - Name: _____ ❑ Male ❑ Female

❑ Living ❑ Deceased Age (if deceased, age at time of death): _____

Medical Conditions (check if applicable):

❑ Heart Condition Specify: _____ Age at diagnosis: _____

❑ Diabetes Age at diagnosis: _____

❑ Hypertension Age at diagnosis: _____

❑ Cancer Specify: _____ Age at diagnosis: _____

❑ Any Hereditary Conditions: Condition(s): _____

Section 6 – Evidence of Insurability (continued)

Sibling #3 - Name: _____		❑ Male	❑ Female
❑ Living ❑ Deceased	Age (if deceased, age at time of death): _____		
Medical Conditions (check if applicable):			
❑ Heart Condition	Specify: _____	Age at diagnosis: _____	
❑ Diabetes		Age at diagnosis: _____	
❑ Hypertension		Age at diagnosis: _____	
❑ Cancer	Specify: _____	Age at diagnosis: _____	
❑ Any Hereditary Conditions:	Condition(s): _____		

Note: If you have more than three siblings, please attach a separate sheet.

Section 7 – Priority Healthcare Insurance Plan Selection

Please check the plan you are applying for:

❑ Gold Plan ❑ Diamond Plan

Please check the deductible level you are applying for:

❑ $1,500 USD ❑ $2,500 USD

❑ $5,000 USD ❑ $10,000 USD

Section 8 – Declarations and Signatures

The Applicant hereby requests that the Insurer issues a Priority Healthcare Insurance policy based on the statements and representations stated throughout the application process. Furthermore, the Applicant hereby declares the statements and answers provided throughout this application process to be complete and true and agrees that such statements and answers shall constitute the application for and form part of the insurance contract and that the insurance shall become effective in accordance with and subject to the terms and conditions of the policy to be issued. The Applicant further agrees that the insurance shall become effective on the Policy Inception Date established by the Insurer, subject to the payment of premium. The Applicant/Proposed Policyholder further agrees that no statement in this Application shall be binding upon the Insurer nor modify its rights.

The Applicant understands that the Insurer may exercise its right to void any policy in the event of nondisclosure or misrepresentation in the Evidence of Insurability.

In case of errors or omissions discovered by the Insurer in this Application, the Insurer is hereby authorized to amend this Application by noting the changes in the section entitled Corrections and Modifications, and acceptance by the Applicant of the policy accompanied by a copy of this Application so amended, shall constitute a ratification of such corrections and modifications.

Claims in process under any other insurance on the Policy Inception Date will not be assumed by the Insurer. Current coverage should not be cancelled until this Application has been approved by the Insurer.

The Applicant consents to any changes being made to the insurance policy, as required under the applicable laws, regulations and/or guidelines.

Signed at _____ on this _____ day of _____, 20_____.

_____ | _____

Name of Applicant | Name of Witness

_____

Name of Parent/Legal Guardian (if applicable)

_____ | _____

Signature of Applicant/Parent/Legal Guardian | Signature of Witness

Section 9 – Agency/Producer Information (for completion by the agency/producer)

Agency Name (please print)

Producer Name (please print)

Street Address | Suite No.

City | Province | Postal Code

Telephone | Fax

Email

Signature | Date (D/M/Y)

Producer Stamp

Producer Number

Section 10 – For Head Office Use Only

Corrections and Modifications

Authorized by	Date (D/M/Y)