



TRAVEL INSURANCE APPLICATION FOR VISITORS TO CANADA

If medical underwriting is required please use the appropriate form.

Language preference English French

STEP 1 APPLICANT INFORMATION (Please Print)

Sex	First Name	Last Name	Birth Date
M / F			MM / DD / YYYY
M / F			MM / DD / YYYY
M / F			MM / DD / YYYY
M / F			MM / DD / YYYY
M / F			MM / DD / YYYY

Address in Canada

City/Prov. Postal Code

Telephone Number () E-mail Address

Beneficiary Name Relationship

Departure Country

STEP 2 APPLICATION DETAILS (Please Print)

Application Date MM / DD / YYYY	Effective Date MM / DD / YYYY	For purchase of additional coverage. Previous Policy Number: _____
Time of Application _____ am _____ pm	Expiry Date MM / DD / YYYY	
Date of Entry to Canada MM / DD / YYYY	No. of Days Coverage _____	

STEP 3 COVERAGE SELECTION

Plan	Sum Insured	Premium Rate	No. of Persons	No. of Days	Total Premium
Hospital and Medical <input type="checkbox"/> Basic <input type="checkbox"/> Select	<input type="radio"/> \$10,000 <input type="radio"/> \$25,000 <input type="radio"/> \$50,000 <input type="radio"/> \$100,000 <input type="radio"/> \$150,000	\$			\$
<input type="checkbox"/> A.D.&D. (25,000 incl. in Select Plan)	<input type="radio"/> \$25,000 <input type="radio"/> \$100,000 <input type="radio"/> \$250,000	\$			\$
<input type="checkbox"/> Flight Accident	<input type="radio"/> \$200,000 <input type="radio"/> \$500,000	\$			\$
<input type="checkbox"/> Trip Interruption	<input type="radio"/> \$800 <input type="radio"/> \$1,500 <input type="radio"/> \$2,000	\$			\$

Minimum premium for Hospital & Medical is for 10 days coverage. Minimum premium for A.D.&D. is \$16. TOTAL PREMIUM DUE \$

STEP 4 PAYMENT AND DECLARATION

<input type="checkbox"/> Visa <input type="checkbox"/> MC <input type="checkbox"/> Amex <input type="checkbox"/> Diners <input type="checkbox"/> Cheque Card No. _____ Expiry Date ____ / ____ Auth. No. _____ Cardholder's Signature _____	Submit this Application to: Agency Code <u>6005</u> <p style="text-align: center;"> WWW.HEALTHQUOTES.CA Phone: 416-746-0667 Toll free: 1-800-474-4474 Fax: 416-746-6208 </p> <p style="font-size: 1.5em; font-family: cursive;">AHLN: KEISTA</p>
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I understand that hospital and medical insurance excludes any sickness or injury occurring during the 180 days immediately preceding the effective date. I also understand that sickness related coverage begins 48 hours from the effective date unless this coverage is purchased prior to arrival in Canada or before the expiry date of an existing TIC Visitors to Canada policy. I declare that I am in good health and know of no reason to seek medical attention.

Signature of insured (or person acting on behalf of Insured) _____ Date (MM/DD/YYYY) _____