

✓ information required to calculate your quote

AwayCare True Senior Guard

EMERGENCY HOSPITAL & MEDICAL INSURANCE

Application

APPLICANT 1

✓ Last Name: _____ ✓ First Name: _____
 ✓ Date of Birth (MM/DD/YYYY): _____ ✓ Gender: _____

Address in Canada

Street: _____ Apt/Unit#: _____
 City: _____ Province: _____
 Postal Code: _____
 Phone Number: _____ E-mail Address: _____

Stability requirement (60 y/o or more)	<input type="checkbox"/> 365 days	<input type="checkbox"/> 180 days	<input type="checkbox"/> 90 days	<input type="checkbox"/> 7 days
Stability requirement (59 y/o or less)	<input type="checkbox"/> 45 days	<input type="checkbox"/> 7 days		

APPLICANT 2

Last Name: _____ First Name: _____
 Date of Birth (MM/DD/YYYY): _____ Gender: _____

Address in Canada

Check box if same address as Applicant 1

Street: _____ Apt/Unit#: _____
 City: _____ Province: _____
 Postal Code: _____
 Phone Number: _____ E-mail Address: _____

Stability requirement (60 y/o or more)	<input type="checkbox"/> 365 days	<input type="checkbox"/> 180 days	<input type="checkbox"/> 90 days	<input type="checkbox"/> 7 days
Stability requirement (59 y/o or less)	<input type="checkbox"/> 45 days	<input type="checkbox"/> 7 days		

IMPORTANT TRAVEL NOTES

I understand that in the event of a claim, the answers I provide herein will be reviewed for accuracy by the Insurer. If they are inaccurate in any way, my claim will be denied.

This insurance is only available if you are a Canadian resident age 15 days or older and covered by a Canadian Government Health Insurance Plan (GHIP) during the entire period of coverage. Benefits under this policy are limited to a maximum of \$25,000 if you do not have valid GHIP coverage at the time any claim is incurred.

**** Treat/Treatment** – a medical, therapeutic or diagnostic procedure ordered, performed or recommended by a physician, including but not limited to prescription medication, surgery or investigative testing that results in a diagnosis of a specific medical condition. Does not include Minor Ailment.

Underwritten by: 

Administered by: 

Eligibility:

You must meet the following eligibility requirements on the departure date of each trip in order to be eligible for coverage.

- 1) Coverage is NOT AVAILABLE to any individual who:
 - a. is travelling against the advice of a physician or knows of any reason to seek consultation during the trip; or
 - b. has a life expectancy of 6 months or less

Are you eligible? Applicant 1: YES NO Applicant 2: YES NO **IF YES, please proceed to the Rate Qualification questions**

If you are NOT eligible, please contact your Agent.

59 years old or younger and/or Family Plans do not require a Rate Qualification and can stop following the eligibility.

Rate Qualification: (60 years or older only)

- 2) At the time of application, how many medications in total do you take or have been ordered to take by a physician to treat one or more of the following conditions:
 - a. Heart condition(s)/disease (do not include aspirin, high blood pressure or cholesterol medications)
 - b. Lung condition(s)/disease (**EXCLUDING** asthma and/or seasonal allergies)
 - c. Diabetes (treated with oral medications or insulin)
 - d. Stroke and/or transient ischemic attack (mini-stroke, TIA) (do not include aspirin)

	Applicant 1	Applicant 2	IF YES;
3 or more medications	<input type="checkbox"/>	<input type="checkbox"/>	STOP - You are eligible for rate category 6
2 medications	<input type="checkbox"/>	<input type="checkbox"/>	STOP - You are eligible for rate category 5
1 medication or none	<input type="checkbox"/>	<input type="checkbox"/>	Please proceed to question 3

- 3) At the time of application, are you being treated**, taking or have been prescribed medication for any of the following (including Aspirin or Entrophen):

<input type="checkbox"/> AIDS or HIV	<input type="checkbox"/> Heart condition(s)/disease (INCLUDING aspirin)
<input type="checkbox"/> Bowel Obstruction or Bowel Surgery	<input type="checkbox"/> Kidney disease (INCLUDING kidney stones & dialysis)
<input type="checkbox"/> Cancer (excluding basal cell/squamous cell skin cancer)	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Lung condition(s)/disease (INCLUDING asthma and/or seasonal allergies)
<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Pancreatic disease
<input type="checkbox"/> Dementia and/or Alzheimer's	<input type="checkbox"/> Parkinson's disease
<input type="checkbox"/> Diabetes (treated with oral medications or insulin)	<input type="checkbox"/> Seizures
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Spleen disease
<input type="checkbox"/> Gastrointestinal Bleeding	<input type="checkbox"/> Stroke (CVA) and/or mini-stroke (TIA) (INCLUDING aspirin)
<input type="checkbox"/> High Blood Pressure (HBP)	<input type="checkbox"/> Ulcerative Colitis

	Applicant 1	Applicant 2	IF YES;
4 or more medical conditions	<input type="checkbox"/>	<input type="checkbox"/>	STOP - You are eligible for rate category 5
3 medical conditions	<input type="checkbox"/>	<input type="checkbox"/>	STOP - You are eligible for rate category 4
2 medical conditions	<input type="checkbox"/>	<input type="checkbox"/>	STOP - You are eligible for rate category 3
1 medical condition	<input type="checkbox"/>	<input type="checkbox"/>	STOP - You are eligible for rate category 2
None	<input type="checkbox"/>	<input type="checkbox"/>	Please proceed to question 4

- 4) Has it been longer than 12 months since you last saw a physician or nurse practitioner **and/or** have you used tobacco products in the last 2 years?

Applicant 1: YES NO Applicant 2: YES NO **If YES, you are eligible for rate category 2**
If NO, you are eligible for rate category 1

Underwritten by:  Northbridge Insurance

Administered by:  AWAYCARE