CAA Emergency Travel & Medical Insurance

Medical Declaration

Effective October 1, 2009

Manulife Financial

Name: ____

Date of Birth: ____________________ (DD / MMM / YY)

Membership Number: ______________________________

Policy Number: ______________________________

NOTICE ON ELIGIBILITY:

YOU ARE NOT ELIGIBLE FOR ANY COVERAGE UNDER THIS POLICY IF:

A. YOU HAVE BEEN DIAGNOSED WITH A TERMINAL ILLNESS FOR WHICH A PHYSICIAN HAS ESTIMATED YOU HAVE LESS THAN 6 MONTHS TO LIVE;

B. YOU HAVE BEEN ADVISED BY A PHYSICIAN NOT TO TRAVEL AT THIS TIME;

C. YOU REQUIRE KIDNEY DIALYSIS;

D. YOU HAVE EVER HAD A BONE MARROW OR ORGAN TRANSPLANT (EXCEPT CORNEA TRANSPLANT);

E. YOU HAVE BEEN DIAGNOSED WITH AND/OR RECEIVED MEDICAL TREATMENT FOR METASTATIC CANCER IN THE LAST 5 YEARS;

F. YOU HAVE BEEN PRESCRIBED OR TAKEN HOME OXYGEN FOR A LUNG CONDITION IN THE LAST 12 MONTHS.

INSTRUCTIONS TO THE APPLICANT:

IT IS IMPORTANT THAT YOU READ THESE INSTRUCTIONS CAREFULLY BEFORE COMPLETING YOUR MEDICAL DECLARATION.

1. Only **YOU**, the applicant, can complete and sign your Medical Declaration, not your spouse or agent. Your CAA travel professional may not assist you in the completion of this document.
2. You must answer each question truthfully. Your prior medical history will be reviewed at time of claim and if any of your answers are found to be untrue or incorrect, your coverage will be null and void (even if the untruth or inaccuracy is not related to the claim reported).
3. Pay particular attention to the Definitions and Terms as they relate to your answers to the questions asked.
4. If you have any doubts about your medical condition(s) as it relates to the questions asked, you must consult your physician for advice **before** completing your Medical Declaration.
5. You must make sure that you complete ALL applicable Sections, initial your Plan type and sign and date your Medical Declaration at the time of application. **INITIAL ONLY ONE PLAN.**
6. **Mistakes cannot be initialled. Please complete another Medical Declaration.**

DEFINITIONS:

Change means you have experienced an increase in symptoms, developed new symptoms, required investigation, required a change in frequency or dosage of medication, required a change in treatment, were hospitalized, required medical consultation (other than a routine examination) OR had a deterioration of an existing condition.

Change in Medication means the medication dosage OR frequency has been reduced, increased, stopped AND/OR new medications have been prescribed.

EXCEPTIONS:

- An adjustment to the insulin OR Coumadin (Warfarin) dosage you are currently taking provided it is not newly prescribed or stopped AND there has been no *change* in your medical condition; AND
- A *change* from brand name medication to a generic brand medication (insofar as the dosage is not modified).

Check-up means a complete medical examination conducted by a physician or nurse practitioner where your medical history is updated, a physical examination is done and any symptoms were diagnosed and any recommended tests were completed.

Medical Emergency means the unforeseeable and emergent occurrence of symptoms for a sickness or injury which, unless treated immediately by a physician, may lead to death or to serious impairment of your health.

Medical Treatment means any reasonable procedure which is medical, therapeutic or diagnostic in nature, which is medically necessary and which is prescribed by a physician. *Medical treatment* includes hospitalization, basic investigative testing, surgery, prescription medication (including prescribed as needed) OR other treatment directly related to the sickness, injury or symptom.

Stable means that you have NOT experienced the following for any sickness, injury or medical condition before your trip: hospitalization AND/OR a medical procedure or intervention AND/OR a *change in medication* AND/OR a *change* in *medical treatment* AND/OR experienced new or more frequent symptoms AND/OR are requiring investigation (other than a routine *check-up*).

TERMS:

Heart Condition means **ANY** disorder relating to your heart. If you are unsure if you have ever had a heart condition, please consult your physician for advice **before** completing your Medical Declaration. Heart conditions include, but are not limited to the following:

- An abnormal cardiac test result
- Any heart valve disorder
- Atrial fibrillation
- Chest pain or discomfort due to your heart, or angina
- Heart attack, or myocardial infarction, or cardiac arrest
- Heart failure
- Heart murmur (Do not include a murmur you had as a child if your physician has advised that you do not have a murmur as an adult)
- Narrowing or blockage of a coronary artery, or coronary artery disease
- Prior heart surgery of any kind, including but not limited to angioplasty, bypass surgery, valvuloplasty, valve replacement, heart ablation surgery, heart transplantation or surgery for any congenital heart disorder
- Rapid, or slow, or irregular heart beats for which your doctor has prescribed medication, or for which you have undergone surgery or cardioversion
- Treatment with a pacemaker and/or a cardiac defibrillator device
- Water on the lungs or swelling of the ankles due to a heart disorder

Lung condition means any disorder involving your lungs. If you are unsure if you have a lung condition, please consult your physician for advice **before** completing your Medical Declaration.

SECTION 1 – ELIGIBILITY (Must be completed)

YES NO

1. Have you had a heart bypass, angioplasty or heart valve surgery **before 2001**?........ ◯ ◯
2. **In the last 6 months**, have you received chemotherapy and/or radiotherapy and/or **received *medical treatment*** for cancer, (other than routine follow-up), **EXCEPT** basal cell and squamous cell skin cancer and breast cancer treated only with hormonal therapy? .... ◯ ◯
3. **In the last 3 years**, have you **received a diagnosis** and/or **received *medical treatment*** and/or **been in hospital** (including emergency department) and/or **been prescribed or taken medication for 3 or more of the following conditions** (if you have **2** or less of these conditions, answer NO): .... ◯ ◯
   - Heart condition
   - Lung condition (medication includes any puffer(s)/inhaler(s) **EXCEPT** a single unrepeated prescription used for a single incident)
   - Diabetes (treated with medication and/or insulin)
   - Stroke/CVA (Cerebrovascular Accident) or mini-stroke/TIA (Transient Ischemic Attack) (including use of aspirin/Entrophen for this condition)
   - Alzheimer's disease, or any other form of Dementia
   - Peripheral vascular disease (blocked or narrowed arteries)?
4. **In the last 2 years,** have you:
   a) been prescribed or taken Lasix or Furosemide for any reason? .... ◯ ◯
   b) had congestive heart failure?........ ◯ ◯
5. **In the last 12 months**, have you been **prescribed** or **taken** Prednisone or **been in hospital** (including emergency department) for a lung condition? .... ◯ ◯
6. **In the last 4 months,** have you been prescribed or taken **7 or more** prescription medications, including any oral, inhaled, or injected medications, as well as any medications applied to the skin that contain any form of nitroglycerine or any drug(s) for angina? **Do not count** the following medications: hormonal replacement therapy (thyroid or menopausal); drugs used for osteoporosis, or traveller's diarrhea; or any form of immunization. **Do not count** topical medications that go in your ears or eyes or on your scalp or skin **EXCEPT:** any form of nitroglycerine or any drug(s) for angina as noted above. .... ◯ ◯
7. **In the last 12 months**, have you **been in hospital** (including emergency department) for a heart condition? .... ◯ ◯

If you answered NO to ALL questions in Section 1, please complete Section 2.
If you answered YES to ANY question in Section 1, PLEASE STOP COMPLETING THIS DECLARATION. You are not eligible to purchase this insurance. Please consult your CAA travel professional for other options available to you. You may be eligible for a medically underwritten plan.

SECTION 2 – Complete ONLY if you have answered "NO" to all Section 1 Questions

YES NO

1. **In the last 4 months,** have you been prescribed or taken **6** prescription medications, including any oral, inhaled, or injected medications, as well as any medications applied to the skin that contain any form of nitroglycerine or any drug(s) for angina? **Do not count** the following medications: hormonal replacement therapy (thyroid or menopausal); drugs used for osteoporosis, or traveller's diarrhea; or any form of immunization. **Do not count** topical medications that go in your ears or eyes or on your scalp or skin **EXCEPT:** any form of nitroglycerine or any drug(s) for angina as noted above. .... ◯ ◯
2. **In the last 3 years**, have you **received a diagnosis** and/or **received *medical treatment*** and/or **been in hospital** (including emergency department) and/or **been prescribed** or **taken medication** for **2 or more** of the following conditions (if you only have **1** or more of these conditions, answer No):
   - Heart condition?
   - Lung condition (medication includes any puffer(s)/inhaler(s) **EXCEPT** a single unrepeated prescription used for a single incident)?
   - Diabetes (treated with medication and/or insulin)?
   - Stroke/CVA (Cerebrovascular Accident) or mini-stroke/TIA (Transient Ischemic Attack) (including use of aspirin/Entrophen for this condition)?
   - Alzheimer's disease or any other form of Dementia?
   - Peripheral vascular disease (blocked or narrowed arteries)? .... ◯ ◯

If you answered NO to ALL questions in Section 2, please move on to Section 3 now. Do not initial here.

If you answered YES to any questions in Section 2, you are eligible for Plan D.

Please initial ____________ you qualify for Plan D which will not cover expenses resulting from a sickness, injury or medical condition that was **not *stable* through the twelve (12) month period before your departure date.** Please move on to **Section 6** to complete your application.

SECTION 3 – Complete ONLY if you have answered "NO" to all Section 1 and Section 2 Questions

YES NO

1. **In the last** **5 years**, have you **received a diagnosis** and/or **had** ***medical treatment*** and/or **been in hospital** (including emergency department) and/or **been prescribed** or **taken medication** for **ANY** of the following conditions:
   - Heart condition? ○ ○
   - Stroke/CVA (Cerebro-Vascular Accident) or mini-stroke/TIA (Transient Ischemic Attack) (including use of aspirin/Entrophen for this condition)? ○ ○
   - Aneurysm or Peripheral vascular disease (blocked or narrowed arteries)? ○ ○
   - Parkinson's disease? ○ ○
   - Diabetes (treated with medication and/or insulin)? ○ ○
   - Lung condition (medication includes any puffer(s)/inhaler(s) **EXCEPT** a single unrepeated prescription used for a single incident)? ○ ○
   - Cirrhosis of the Liver? ○ ○
   - Alzheimer's disease or any other form of Dementia? ○ ○
2. **In the last 5 years,** have you smoked or used any tobacco products **and been prescribed or taken** any puffer(s)/inhaler(s)? ○ ○
3. **In the last 6 months**, have you **received advice** or ***medical treatment*** for a *medical emergency* **more than once** in the emergency room of a hospital? ○ ○
4. **In the last 3 months**, have you **been prescribed** or **taken** a **total** of **3 or more medications** for high blood pressure (hypertension) **and/or** a heart condition? ○ ○
5. **In the last 2 years**, have you **been diagnosed with** and/or **received** ***medical treatment*** and/or **been in hospital** (including emergency department) and/or **been prescribed** or **taken medication** for (**Check only those that apply**):

   - ☐ bowel obstruction
   - ☐ bowel surgery
   - ☐ diverticular disorder requiring prescription medication or surgery
   - ☐ gastrointestinal bleeding
   - ☐ bleeding or perforated ulcer(s)
   - ☐ chronic bowel disorder
   - ☐ liver disorder
   - ☐ pancreas disorder
   - ☐ kidney disorder (including stones)
   - ☐ gall bladder disorder (including stones. If gall bladder has been removed, DO NOT CHECK))

   Did you Check **2 or more** conditions and/or have you had **2 or more** incidents of any condition listed in this question? ○ ○

If you answered NO to ALL questions in Section 3, please move on to Section 4 now. Do not initial here.

If you answered YES to any questions in Section 3, you are eligible for Plan C.

Please initial ___________ you qualify for Plan C which will not cover expenses resulting from a sickness, injury or medical condition that was **not** ***stable*** **through the twelve (12) month period before your departure date.** Please move on to **Section 6** to complete your application.

SECTION 4 – Complete ONLY if you have answered "NO" to all Section 1, 2 and Section 3 Questions

YES NO

1. **In the last 5 years**, have you smoked or used any tobacco products? ○ ○
2. **In the last 2 years**, have you **been diagnosed** with or **received *medical treatment*** and/or **been in hospital** and/or **been prescribed** or **taken medication**: **(Check only those that apply):**

- ☐ a blood disorder treated by a Hematologist or an Internist
- ☐ bowel obstruction
- ☐ bowel surgery
- ☐ diverticular disorder requiring prescription medication or surgery
- ☐ gastrointestinal bleeding
- ☐ bleeding or perforated ulcer(s)
- ☐ chronic bowel disorder
- ☐ liver disorder
- ☐ pancreas disorder
- ☐ kidney disorder (including stones)
- ☐ gall bladder disorder (including stones. If gall bladder has been removed, DO NOT CHECK)

Did you Check **ANY** of the conditions listed in this question? ○ ○

3. **In the last 12 months**, have you **been diagnosed** with or **received *medical treatment*** for cancer (other than routine follow-up), **EXCEPT** basal cell and squamous cell skin cancer and breast cancer treated only with hormonal therapy? ○ ○
4. **In the last 12 months**, have you **been prescribed** or **taken** a puffer/inhaler? ○ ○
5. If you are age **65 or over, in the last 6 months,** have you had a fall that you reported to a physician? If you are age 64 or under, answer No. ○ ○

If you answered NO to ALL questions in Section 4, please move on to Section 5 now. Do not initial here. If you answered YES to ONE OR MORE questions in Section 4, you are eligible for Plan B.

Please initial ___________ you qualify for Plan B which will not cover expenses resulting from a sickness, injury or medical condition that was **not *stable* through the six (6) month period before your departure date.** Please move on to **Section 6** to complete your application.

SECTION 5 – Complete ONLY if you have answered "NO" to all Section 1, 2, 3 and Section 4 Questions

YES NO

1. Has it been more than **18 months** since your last regular *check-up* with a physician or nurse practitioner? ○ ○
2. Do you have diabetes that is **ONLY** treated by diet? ○ ○
3. Have you **ever** had a heart condition or stroke/CVA (Cerebro-Vascular Accident) or a mini-stroke/TIA (Transient Ischemic Attack)? ○ ○
4. Do you have high blood pressure (hypertension) for which you have **been prescribed** or **taken 2** medications? ○ ○
5. **In the last 12 months** have you **been prescribed** or **taken** or have you **refilled more than 2** prescriptions for the treatment of pain? ○ ○

If you answered YES to ONE OR MORE questions in Section 5, you are eligible for Plan A.

Please initial ___________ you qualify for Plan A which will not cover expenses resulting from a sickness, injury or medical condition that was **not *stable* through the three (3) month period before your departure date.** Please move on to **Section 6** to complete your application.

If you answered NO to ALL questions in Section 5, you are eligible for Plan A +.

Please initial ___________ you qualify for Plan A + which will not cover expenses resulting from a sickness, injury or medical condition that was **not *stable* through the three (3) month period before your departure date.** Please move on to **Section 6** to complete your application.

SECTION 6 – Agreement, Understanding and Authorization

Please read the following important statements carefully. Once you have read and understand the statements, please sign below to complete this Medical Declaration.

- I personally completed this Medical Declaration and all information disclosed on it is true and accurate. I fully understand that if any of my answers are untrue or incorrect, then any coverage offered will be null and void.
- I confirm that I read and understood the **Instructions to Applicant and Notice on Eligibility section on the reverse side of this Medical Declaration Form**, prior to completing my Medical Declaration.
- I understand Manulife Financial, its agents, third party administrators or its legal representatives may investigate any claim. I authorize any hospital, physician, other medical service provider, or any other organization or person that has any records or knowledge of me and my health to release to third party administrators, CAA and/or Manulife Financial and its reinsurers any such information for the purpose of this application and contract and any subsequent claim.
- I understand that if I am purchasing the Canada Plan, all travel must occur within Canada for this coverage to be effective and No Pre-existing Medical Condition Exclusion will apply.

Applicant's Signature ______________________________ **Date of Application** ____________________
DD / MMM / YY

NOTICE ON PRIVACY AND CONFIDENTIALITY

The specific and detailed information requested on the application form is required to process the application. To protect the confidentiality of this information, Manulife Financial will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims relative to the insurance applied for. Access to this file will be restricted to those Manulife Financial employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. Your consent to the use of personal information to offer you products and services which are endorsed or sponsored by CAA is optional and if you wish to discontinue such use, you may write to Manulife Financial at the address shown below, or to your CAA club. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Affinity Markets, Manulife Financial, 6th Floor, 2 Queen Street East, Toronto, Ontario M5W 5M3.

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