



For more information, call 1-800-360-3234 or visit Ingle online at www.ingletravel.com

Please send your completed application and your cheque payable to:

Ingle International & Imagine Financial Ltd.
460 Richmond Street West, Suite 100
Toronto, Ontario M5V 1Y1

For Broker / Sales Agent Use Only

10 26 APP ECA 0710 000

Applicant 1 Policy Number:

Applicant 2 Policy Number:

Date Issued (D/M/Y):

Your personal information is collected for the purpose of providing you with insurance services, claims analysis and payments.
For a copy of the etfs Privacy Policy, please see www.etfsinc.com. For Privacy Information, please see www.rsagroup.ca.

A.: Are you eligible?

You must meet the following criteria to be eligible for this insurance:

1. You must be a Canadian resident and be covered by the government health insurance plan (GHIP) of your Canadian province or territory of residence for the entire duration of your trip.
2. You must NOT be travelling against the advice of a physician or have been diagnosed with a *terminal illness* or *metastatic cancer*.
3. You must NOT have a kidney disease requiring dialysis.
4. You must NOT have been prescribed or used home oxygen during the 12 months prior to your departure date.
5. You must NEVER have been diagnosed with AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus).

B.: Definitions

Throughout the Application, defined words are written in italics. Please refer to them as they are important definitions.

1. **Terminal illness:** means that you have a medical condition that is cause for a physician to estimate that you have less than 6 months to live or for which palliative care has been received.
2. **Metastatic cancer:** means a cancer that has spread from its original site to one or more other area(s) of the body.
3. **Stable:** means any medical condition (other than a *minor ailment*) for which all the following statements are true:
 - a. There has been no new diagnosis, treatment or prescribed medication.
 - b. There has been no change in treatment or change in medication, including the amount of medication to be taken, how often it is taken, the type of medication or change in treatment frequency or type.
Exceptions: the routine adjustment of Coumadin, Warfarin, insulin or oral medication to control diabetes (as long as they are not newly prescribed or stopped) and a change from a brand name medication to a generic brand medication (provided that the dosage is not modified);
 - c. There have been no new symptoms, more frequent symptoms or more severe symptoms.
 - d. There have been no test results showing deterioration.
 - e. There has been no hospitalization or referral to a specialist (made or recommended) and you are not awaiting the results of further investigations for that medical condition.
4. **Minor ailment:** means any sickness or injury which does not require: the use of medication for a period of greater than 15 days; more than one follow up visit to a physician, hospitalization, surgical intervention or referral to a specialist; and which ends at least 30 consecutive days prior to the departure date of each trip. However, a chronic condition or complications of a chronic condition are not considered a minor ailment.

C.: Pre-Existing Medical Condition Exclusions

This insurance does not cover losses or expenses caused directly or indirectly, in whole or in part, by:

1. Any sickness, injury or medical condition (other than a *minor ailment*) that was not *stable* at any time during the 180 days prior to each departure date.
2. Your heart condition, if **any** heart condition was not *stable* at any time during the 180 days prior to each departure date.
3. Your lung condition, if:
 - a. **any** lung condition was not *stable*; or
 - b. you have been treated with home oxygen or taken oral steroids (e.g., prednisone) for **any** lung condition, at any time during the 180 days prior to each departure date.



D.: Personal Information

Applicant 1	First Name _____	Last Name _____	Date of Birth (D/M/Y) ____/____/____ <input type="checkbox"/> Male <input type="checkbox"/> Female
Applicant 2	First Name _____	Last Name _____	Date of Birth (D/M/Y) ____/____/____ <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address	Street _____	City _____	Province _____
	Postal Code _____	Telephone _____	E-mail _____
Destination Address	Street _____	City _____	Province / State / Country _____
	Postal / Zip Code _____	Telephone _____	E-mail (if different from home e-mail) _____
Emergency Contact	First Name _____	Last Name _____	Telephone _____
Dependents			
For Family Plans only	First Name _____	Last Name _____	Date of Birth (D/M/Y) ____/____/____ <input type="checkbox"/> Male <input type="checkbox"/> Female
	First Name _____	Last Name _____	Date of Birth (D/M/Y) ____/____/____ <input type="checkbox"/> Male <input type="checkbox"/> Female
	First Name _____	Last Name _____	Date of Birth (D/M/Y) ____/____/____ <input type="checkbox"/> Male <input type="checkbox"/> Female

If additional space is required, please attach an additional sheet of paper.

E.: Trip Information

Check the applicable Plan you are applying for.

Applicant 1	Applicant 2
Plans <input type="checkbox"/> Multi-Trip Annual <input type="checkbox"/> 9-Day <input type="checkbox"/> 16-Day <input type="checkbox"/> 30-Day <input type="checkbox"/> 60-Day <input type="checkbox"/> All-Inclusive Multi-Trip Annual <input type="checkbox"/> 9-Day <input type="checkbox"/> 16-Day <input type="checkbox"/> 30-Day <input type="checkbox"/> 60-Day <input type="checkbox"/> 40-Day PSHCP Supplemental Effective Date (D/M/Y): ____/____/____ <input type="checkbox"/> Single Trip Daily or Top-Up Plan <input type="checkbox"/> Single Trip Non-Medical Plan* <input type="checkbox"/> Canada Plan Departure Date (D/M/Y): ____/____/____ *Trip Value: \$ _____ Expiry Date (D/M/Y): ____/____/____ Effective Date** (D/M/Y): ____/____/____	Plans <input type="checkbox"/> Multi-Trip Annual <input type="checkbox"/> 9-Day <input type="checkbox"/> 16-Day <input type="checkbox"/> 30-Day <input type="checkbox"/> 60-Day <input type="checkbox"/> All-Inclusive Multi-Trip Annual <input type="checkbox"/> 9-Day <input type="checkbox"/> 16-Day <input type="checkbox"/> 30-Day <input type="checkbox"/> 60-Day <input type="checkbox"/> 40-Day PSHCP Supplemental Effective Date (D/M/Y): ____/____/____ <input type="checkbox"/> Single Trip Daily or Top-Up Plan <input type="checkbox"/> Single Trip Non-Medical Plan* <input type="checkbox"/> Canada Plan Departure Date (D/M/Y): ____/____/____ *Trip Value: \$ _____ Expiry Date (D/M/Y): ____/____/____ Effective Date** (D/M/Y): ____/____/____
Top-Ups Name of the other Insurer: _____ Number of Pre-insured days: _____	Top-Ups Name of the other Insurer: _____ Number of Pre-insured days: _____

F.: Premium and Payment

For manual applications, please complete the Premium Calculation – Plans without Medical Questionnaire page to determine each Applicant's total premium.

Total Premium	\$ Applicant 1	+	\$ Applicant 2	=	\$ TOTAL
Method of Payment	<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> AMEX <input type="checkbox"/> Cheque made payable to the broker or sales agent indicated on the front of this application.				
Card Number _____	Expiry Date (M/Y) _____		Signature of Cardholder _____	Date Signed (D/M/Y) _____	