

Fax Number(s)

## Individual Expatriate Health Insurance

## **Application**



For Office Use Only	BROKER		POLICY NUMBER								
Primary Applicant Information (Please print in block letters)  38 01 APP ECA 1116 000											
(Mr, Mrs, Miss, Ms, Dr, Other)											
Title	First Name(s)	Last Name									
D M Y	M / F										
Date of Birth	Sex Provincia	x Provincial Health Card Number (optional)									
Nationality on Passport(s)		Country of Residence									
	Coveragi (subject	ge is NOT available for residents of Switzerland, Germany and Abu Dhabi state, in the United Arab Emirates to change without notice).									
Occupation											
Address		Mailing Addre	ess (if different from the adjacent)								
Telephone Number - Residence			mber - Work								
Fax Number		 E-mail Address	E-mail Address								
Emergency Contact: Name and Te	lephone Number										
Dependent Informatio	n - If there is insufficient space, please	use a separate sheet and indicate that y	ou have done so by ticking this box								
	1 <sup>st</sup> Dependent	2 <sup>nd</sup> Dependent	3 <sup>rd</sup> Dependent	4 <sup>th</sup> Dependent							
Last name											
First Name(s)											
Date of Birth (D/M/Y)											
Sex	Male Female	Male Female	Male Female	Male Female							
Foreign Country of Residence											
Nationality											
Relation to Applicant											
Occupation											
Family Physician Information This section must be filled out compared to the section of the sect	rmation pletely. (If you do not have a family phys	ician in Canada, please provide the inforr	mation for the physician you visited mos	st recently.)							
Name(s) of General Practitioner	r(s)/Family Physician(s)										
Name(e) of Contrar Fractions	(o)/r ammy r nyonoram(o)										
Telephone Number(s)											

Address(es) of General Practitioner(s)/Family Physician(s)

## **DECLARATION** - A copy of this declaration shall be as valid as the original. Part A - Pre-existing medical conditions One year moratorium I/we understand that any condition (except for a minor ailment as defined in the policy) for which the insured person(s) has sought or received medical treatment, advice, follow-up visits, counseling, or has taken prescription drugs within one hundred and eighty (180) days prior to becoming insured under this policy, will not be covered until a continuous period of not less than three hundred and sixty-five (365) consecutive days has passed during which time the insured person(s) has not sought or received medical treatment, advice, follow-up visits, counseling, nor has taken prescription drugs related to such condition. Part B - Release of Medical Information By signing this application, I also hereby direct and authorize any physician, health care practitioner, hospital or other medical care facility, pharmacy, the Ministry of Health or any other person who has attended and examined me or who has knowledge or records of me or my health, to furnish to MSH International and to Global Excel Management Inc. any or all information with respect to my sickness, injury, medical history, consultations, medicines or treatment and copies of all health or medical records. Part C - Disclosure I/we shall read the policy wording and I/we understand it to be part of the Insurance Contract issued as a result of this application. I/we confirm that I/we are purchasing this insurance prior to departure from Canada or prior to expiry of an existing insurance underwritten by Royal & Sun Alliance Insurance Company of Canada. To the best of my/our knowledge and belief, the information provided in connection with this application, whether in my/our own hand or not, is true and I/we have not withheld any material facts. I/we understand that non-disclosure or misrepresentation of any material fact may entitle the insurer to void the insurance. A material fact is one likely to influence acceptance or assessment of this application by the insurer. If I am/we are in any doubt as to whether a fact is material or not, I/we have disclosed it (on a separate sheet where necessary). This application and the information provided in connection therewith contains statements upon which the insurer will rely in deciding whether to accept this insurance and in determining the terms and conditions of such acceptance. I/we understand that the signing of this application does not bind me/us to complete, or the insurer to accept, this insurance. Primary Applicant's Signature: Date of Signature: **Policy Dates** (coverage cannot be confirmed before RSA receives this application). You can choose 6, 9 or 12 months coverage by ticking the appropriate box. Effective Date М ☐ 9 months 12 months ☐ 6 months Coverage must be purchased prior to departure from Canada, unless purchasing prior to expiry of an insurance underwritten by Royal & Sun Alliance Insurance Company of Canada. Type of Coverage Refer to the rate guide for premium options. Worldwide coverage **excluding** the United States Worldwide coverage **including** the United States **Premium Calculation** PREMIUM PER APPLICANT Subtotal Primary 1st Dependent 2<sup>nd</sup> Dependent 3rd Dependent 4th Dependent **DEDUCTIBLE OPTIONS** NO Deductible (Automatic) \$250 (Subtract 7% from premium) \$1.000 (Subtract 16% from premium) \$5,000 (Subtract 27% from premium) \$500 (Subtract 12% from premium) **PREMIUM PAYMENT OPTIONS & AMOUNTS** (Semi-annual and quarterly payment options are only available for the 12 month coverage.) Annually Semi-annually Quarterly (add 4% to premium) (add 8% to premium) TOTAL PREMIUM DUE

## **Method of Payment**

U Visa	MasterCard	Amex	Cheque made payable to RSA. You must provide RSA with all post dated cheques for semi-annual or quarterly payment.								
			M	Υ			D	М	Υ		
Card Number		Expiry Date		Signature of Cardholder		Date Signed					

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