

## VERSION M09 MEDICAL QUESTIONNAIRE - AGE 55 OR OVER ONLY

<b>Applicant 1 Name</b> PLEASE PRINT	<b>Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Date of Birth</b> MM/DD/YY	<b>Applicant 2 Name</b> PLEASE PRINT	<b>Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Date of Birth</b> MM/DD/YY
---	--	----------------------------------	---	--	----------------------------------

**ABOUT THE MEDICAL QUESTIONS –** Medical questions help us to determine eligibility, access risk and determine the premium rate that is appropriate. If you are uncertain of your answers to any of the medical questions, please consult your doctor before completing this application for insurance.

### ELIGIBILITY

	<b>Applicant 1</b>	<b>Applicant 2</b>
1. Have you been advised by a physician not to travel at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you require kidney dialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you <b>ever</b> had a bone marrow or organ transplant (excluding corneal transplant)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you had a heart bypass, angioplasty or heart valve surgery more than <b>ten (10) years</b> ago?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the last <b>five (5) years</b> , have you been diagnosed with and/or had treatment for metastatic cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. In the last <b>six (6) months</b> , have you received chemotherapy and/or radiotherapy and/or other treatment, other than routine follow-up, for cancer ( <b>except</b> basal cell and squamous cell skin cancer, and breast cancer treated only with hormonal therapy)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. In the last <b>twelve (12) months</b> , have you been prescribed or taken Prednisone or oxygen or been hospitalized (as an in-patient or seen in the emergency department) for a lung condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. In the last <b>two (2) years</b> , have you: a) been prescribed or taken Lasix or furosemide for any reason? b) had congestive heart failure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. In the last <b>twelve (12) months</b> , have you been hospitalized (as an in-patient or seen in the emergency department) for a heart condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. In the last <b>four (4) months</b> , have you been prescribed or taken <b>six (6) or more</b> prescription medications? <b>Do not count</b> the following medications: hormone replacement therapy (thyroid or menopausal); drugs used for osteoporosis, or traveller's diarrhea; or any form of immunization. <b>Do not count</b> topical medications that go in your ears or eyes or on your scalp or skin <b>except:</b> any form of nitroglycerine or any drug(s) for angina.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. In the last <b>three (3) years</b> , have you been prescribed or taken medication for and/or been diagnosed with and/or had treatment for and/or been hospitalized (as an in-patient or seen in the emergency department) for any <b>two (2)</b> of the following (If you only have <b>one (1)</b> of the following conditions, answer <b>NO</b> ): <ul style="list-style-type: none"> <li>• Heart condition</li> <li>• Lung condition (medication includes puffer(s)/inhaler(s) <b>except</b> an unrepeat prescription used for a single episode)</li> <li>• Diabetes (treated with medication and/or insulin)</li> <li>• Stroke/CVA (cerebrovascular accident) or mini-stroke/TIA (transient Ischemic attack) including the use of aspirin/Entrophen for the condition</li> <li>• Narrowed or blocked artery in the legs (also called Peripheral Vascular Disease)</li> <li>• Alzheimer's disease, or any other form of dementia?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**ELIGIBILITY REQUIREMENT.** If you answered "YES" to ANY of the above questions, you are **not eligible** to purchase this insurance. **DO NOT** complete this application. Contact your agent/broker or 21st Century Travel Insurance to obtain a quote for the Individual Medical Underwriting Plan. If you answered "NO" to ALL of the above questions, you are **eligible** to purchase this insurance. Proceed to **FIND YOUR RATE CATEGORY**.

### FIND YOUR RATE CATEGORY

#### Part 1 – Rate qualification

	<b>Applicant 1</b>	<b>Applicant 2</b>
1. In the last <b>five (5) years</b> , have you been prescribed or taken medication for and/or been diagnosed with and/or had treatment and/or been hospitalized (as an in-patient or seen in the emergency department) for <u>any</u> of the following: <ul style="list-style-type: none"> <li>• Heart condition</li> <li>• Stroke/CVA (cerebrovascular accident) or mini-stroke/TIA (transient ischemic attack) including the use of aspirin/Entrophen for the condition</li> <li>• Aneurysm</li> <li>• Narrowed or blocked artery in the legs (also called Peripheral Vascular Disease)</li> <li>• Diabetes (treated with medication and/or insulin)</li> <li>• Lung condition (medication includes any puffer(s)/inhalers(s) <b>except</b> an unrepeat prescription used for a single episode)</li> <li>• Cirrhosis of the liver</li> <li>• Alzheimer's disease, or any other form of dementia, or Parkinson's disease?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the last <b>five (5) years</b> , have you smoked or used tobacco products <b>and</b> been prescribed or used any puffer(s)/inhaler(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the last <b>six (6) months</b> , have you received advice or treatment <b>more than once</b> in the emergency room of a hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the last <b>three (3) months</b> , have you been prescribed or taken a total of <b>three (3) or more</b> medications for high blood pressure (hypertension) and/or a heart condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered "YES" to ANY of the questions in Part 1, you qualify for Rate Category C. If you answered "NO" to ALL the questions in Part 1, proceed to Part 2.

#### Part 2 – Rate qualification

	<b>Applicant 1</b>	<b>Applicant 2</b>
1. In the last <b>two (2) years</b> , have you been prescribed or taken medication for and/or been diagnosed with and/or received treatment and/or been hospitalized (as an in-patient or seen in the emergency department) for <u>any</u> of the following conditions: <ul style="list-style-type: none"> <li>• Bowel obstruction or surgery</li> <li>• Diverticular disorder requiring prescription medication or surgery</li> <li>• Gastrointestinal bleeding</li> <li>• Bleeding or perforated ulcer(s)</li> <li>• Chronic bowel disorder</li> <li>• Liver disorder</li> <li>• Pancreatic disorder</li> <li>• Kidney disorder (including stones)</li> <li>• Gall bladder disorder (including stones. If gall bladder has been removed, answer NO)?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you have two (2) or more conditions listed in Part 2, you qualify for Rate Category C. If you have one (1) condition listed in Part 2, you qualify for Rate Category B. If you do not have ANY of the conditions listed in Part 2, proceed to Part 3.

#### Part 3 – Rate qualification

	<b>Applicant 1</b>	<b>Applicant 2</b>
1. In the last <b>two (2) years</b> , have you been diagnosed with, and/or been hospitalized (as an inpatient or seen in the emergency department), and/or received treatment, and/or been prescribed medication by a Hematologist or an Internist for a blood disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the last <b>twelve (12) months</b> , have you been prescribed or used a puffer/inhaler?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the last <b>twelve (12) months</b> , have you been diagnosed with or received treatment for cancer other than routine follow-up ( <b>except</b> basal cell and squamous cell skin cancer, and breast cancer treated only with hormonal therapy)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you over 65, <b>and</b> have you had a fall for which you sought medical attention in the last <b>six (6) months</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered "YES" to ANY of the questions in Part 3, you qualify for Rate Category B. If you answered "NO" to ALL of the questions in Part 3, proceed to Part 4.

#### Part 4 – Rate qualification

	<b>Applicant 1</b>	<b>Applicant 2</b>
1. In the last <b>two (2) years</b> , have you smoked or used any tobacco products?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered "YES" to the question in Part 4, you qualify for Rate Category A. If you answered "NO" to the question in Part 4, you qualify for Rate Category A+.

**PLEASE READ CAREFULLY BEFORE SIGNING:** I apply to The Manufacturers Life Insurance Company (Manulife Financial) for insurance under the Medicare International Travel Insurance policy administered by 21st Century Travel Insurance Limited (o/a 21st Century Travel Insurance Services in British Columbia). I declare that all information I have provided on this application form and medical questionnaire (if required) is true and complete. I have read the Medicare International Travel Insurance policy and understand the terms, conditions and exclusions (including the pre-existing condition exclusion) that apply to my coverage. I understand that if I misrepresent any material information provided in this application, Manulife Financial will void my policy and I will not be covered for any benefits under this policy. I authorize any hospital, physician, other medical service provider or any other organization or person that has my records or knowledge of me or my health to release to the assistance and claims service provider appointed by Manulife Financial, and/or Manulife Financial and its reinsurers and/or 21st Century Travel Insurance Limited, any such information for the purpose of this application and contract and any subsequent claim.

**Applicant 1 Signature:** \_\_\_\_\_ **Applicant 2 Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_