



CPSA ANNUAL TRAVEL INSURANCE APPLICATION

To Enroll, call 1-888-281-2772

Mail or fax: CPSA Travel Insurance Administrator - 8001 Weston Road, Suite 300, Woodbridge, ON L4L 9C8 Fax: 905-856-1539

Applicants must meet the Eligibility Requirements as stated in the Policy. Failure to meet these Eligibility Requirements will result in the insurance Policy being "null and void".

APPLICANT INFORMATION

CPSA MEMBER #

BIRTH DATE DD MM YY

MR/MRS/DR/MISS LAST NAME FIRST NAME

SPOUSE'S NAME (CO-APPLICANT) BIRTH DATE DD MM YY

CHILD'S NAME BIRTH DATE DD MM YY CHILD'S NAME BIRTH DATE DD MM YY

NUMBER & STREET NAME CITY

PROVINCE POSTAL CODE TELEPHONE # ()

PLEASE INDICATE: PLAN SELECTION A B

PLEASE INDICATE: OPTIONAL TRIP RIDER SELECTION C D E

PLEASE INDICATE: MAXIMUM # OF DAYS PER TRIP 15 30

PLAN SELECTION

- A DELUXE ANNUAL PLAN**
MEDICAL \$5 MILLION / BAGGAGE \$1,000
TRIP CANCELLATION & INTERRUPTION \$1,000
 - B STANDARD ANNUAL PLAN**
MEDICAL \$5 MILLION
- OPTIONAL PER TRIP RIDERS**
- C TRIP CANCELLATION RIDER**
UP TO AN ADDITIONAL \$11,000
 - D PERSONAL EFFECTS RIDER**
CELL PHONE \$500 / GOLF CLUBS \$1,000 / LAP TOP COMPUTER \$2,500
 - E RENTAL VEHICLE PHYSICAL DAMAGE RIDER**
\$50,000

ANNUAL TRAVEL INSURANCE RATES

RATES SHOWN ARE PER PERSON-PER TRIP EXCLUDING APPLICABLE PROVINCIAL SALES TAX.
FAMILY RATE: CONSISTS OF ONE OR TWO ADULTS PLUS CHILDREN BETWEEN 0-25 YEARS OF AGE.

A DELUXE ANNUAL PLAN

DAYS PER TRIP	AGE 0-59	AGE 60-64
15	\$ 69.00	\$109.00
30	\$115.00	\$155.00

FAMILY RATE: MULTIPLY THE ADULT RATE BY 2.5 WHEN TRAVELLING WITH CHILDREN UNDER 21 IF BEING SUPPORTED OR UNDER 26 IF FULL TIME STUDENT.

B STANDARD ANNUAL PLAN

DAYS PER TRIP	AGE 0-59	AGE 60-64
15	\$46.00	\$ 75.00
30	\$69.00	\$109.00

FAMILY RATE: MULTIPLY THE ADULT RATE BY 2 WHEN TRAVELLING WITH CHILDREN UNDER 21 IF BEING SUPPORTED OR UNDER 26 IF FULL TIME STUDENT.

ADDITIONAL COVERAGE(S) (RIDERS) APPLY ONLY TO THE SINGLE TRIP FOR WHICH THE COVERAGE IS PURCHASED. RIDERS MAY ONLY BE PURCHASED IN CONJUNCTION WITH A DELUXE OR STANDARD ANNUAL PLAN.

OPTIONAL PER TRIP RIDERS

C TRIP CANCELLATION (UP TO AN ADDITIONAL \$11,000)	\$ 7.00 PER \$100
D PERSONAL EFFECTS - CELL PHONE \$500 / GOLF CLUBS \$1,000 / LAP TOP COMPUTER \$2,500	\$ 9.00 PER DAY
E RENTAL VEHICLE PHYSICAL DAMAGE - \$50,000	\$13.00 PER DAY

PREMIUM CALCULATION

	PREMIUM
A DELUXE ANNUAL PLAN OR B STANDARD ANNUAL PLAN	\$ _____
C TRIP CANCELLATION RIDER ADDITIONAL SUM INSURED \$ _____ DEPARTURE DATE <input type="text"/> DD <input type="text"/> MM <input type="text"/> YY RETURN DATE <input type="text"/> DD <input type="text"/> MM <input type="text"/> YY	\$ _____
D PERSONAL EFFECTS RIDER DEPARTURE DATE <input type="text"/> DD <input type="text"/> MM <input type="text"/> YY RETURN DATE <input type="text"/> DD <input type="text"/> MM <input type="text"/> YY	\$ _____
E RENTAL VEHICLE PHYSICAL DAMAGE RIDER DEPARTURE DATE <input type="text"/> DD <input type="text"/> MM <input type="text"/> YY RETURN DATE <input type="text"/> DD <input type="text"/> MM <input type="text"/> YY	\$ _____
TOTAL PREMIUM	\$ _____

Coverage becomes effective on the date your Application and payment are received by the Plan Administrator.
Credit Card Authorization: I hereby authorize Pottruff & Smith Travel Insurance Brokers, Inc., to process on my Credit Card the Total Premium Due above.

Cardholder Signature Credit Card Number Visa MasterCard Diners American Express Expiry Date MM YY

IMPORTANT: Your policy is subject to the following conditions which may limit coverage or result in your policy being null & void.

ACCEPTANCE OF CONDITIONS: I/we have read and understand the terms of the Coverage Eligibility Requirements, the Qualification Requirements and the Pre-Existing conditions Exclusion applicable to the Plan that I/we have selected, and I/we accept that in the event of a claim, my/our medical records will be obtained to confirm that I/we met the eligibility and plan qualifications for the selected plan both on the Application Date and on the Departure Date.

I/we agree that if I/we do not meet both the eligibility and plan requirements for the plan I/we select or if any material misrepresentation or evasion is contained herein, then Reliable Life Insurance Company will void my/our policy and no coverage will be provided.

I/we understand that only Treatment for Medical Emergencies is covered under this insurance.

CPSA Member Signature Date DD MM YY Co-Applicant Signature Date DD MM YY

For office use only: DATE RECEIVED APPROVED BY DATE APPROVED DATE ENTERED POLICY NUMBER