Emergency Medical Travel Insurance - Application.

Each Applicant must complete, sign and date the Application where indicated. Applications with missing signatures will result in the insurance policy being "null and void".

CPSA Member Number

APPLICANT 1

D M Y

Mr/Mrs/Dr/Miss Last Name First Name Birth Date

Government Health Insurance Plan # Version Code Ontario Res. Quebec Residents Maiden Name

( )

Name of family Physician in Canada Physician Telephone #

Home Address in Canada

Number & Street Name City

( )

Province Postal Code Telephone #

Check Plan You Qualify For ☐ **PLAN A** ☐ **PLAN B** ☐ **PLAN C**

1. Single Trip Premium*

Coverage Start Date (D M Y) Coverage End Date (D M Y) Departure Date (D M Y)

Total No. Days Covered

Days

PREMIUM $ ①

Single Trip can be used to Top-Up the Annual Multi-Trip

ARE YOU TOPPING UP? ☐ **YES** ☐ **NO**

2. Annual Multi-Trip Premium ☐ 15 DAY ☐ 30 DAY

Policy Start Date (D M Y)

PREMIUM $ ②

A. Total Premium Applicant 1

① + ② $ Ⓐ

APPLICANT 2

D M Y

Mr/Mrs/Dr/Miss Last Name First Name Birth Date

Government Health Insurance Plan # Version Code Ontario Res. Quebec Residents Maiden Name

( )

Name of family Physician in Canada Physician Telephone #

Destination Address Outside Canada

Number & Street Name City

( )

State Zip Code Telephone #

Check Plan You Qualify For ☐ **PLAN A** ☐ **PLAN B** ☐ **PLAN C**

1. Single Trip Premium*

Coverage Start Date (D M Y) Coverage End Date (D M Y) Departure Date (D M Y)

Total No. Days Covered

Days

PREMIUM $ ①

Single Trip can be used to Top-Up the Annual Multi-Trip

ARE YOU TOPPING UP? ☐ **YES** ☐ **NO**

2. Annual Multi-Trip Premium ☐ 15 DAY ☐ 30 DAY

(D M Y)

PREMIUM $ ②

B. Total Premium Applicant 2

① + ② $ Ⓑ

TOTAL PREMIUM FOR APPLICANTS 1 AND 2 Ⓐ + Ⓑ $

METHOD OF PAYMENT: Cheque Payable to CPSA Travel Insurance

☐ Cash ☐ Cheque ☐ Credit Card

CREDIT CARD NUMBER **EXPIRY DATE** M Y ☐ Visa ☐ MasterCard

I hereby authorize the charge on my Credit Card for the Total Amount Due as shown above. ____________ **SIGNATURE**

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 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 have selected, and I accept that in the event of a claim, my medical records will be obtained to confirm that I met the eligibility and plan qualifications for the selected plan both on the Application Date and on the Departure Date.

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

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

AUTHORIZATION & RELEASE: I hereby consent to and authorize Reliable Life Insurance Company and its representative Pottruff & Smith, to collect, use, share, and to disclose to third parties (such as such as other insurance companies, health organizations and Government Health Insurance Plans or such other person or entity whose access has been authorized by law) my personal information for the purposes of adjudicating and processing any claim submitted by me or on my behalf, specifically in (a) determining my eligibility for coverage, (b) determining my qualifications for the plan I selected, (c) reviewing my medical records for the period applicable to the Pre-Existing Conditions Exclusion, (d) assessing insurance risks, (e) managing and adjudicating claims based on the terms and conditions of the policy, and (f) negotiating or settling payments to third parties.

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 or examined me or who has knowledge or record of me or my health, to furnish Reliable Life Insurance Company, or its representative, Pottruff & Smith, any or all information with respect to any illness, injury, medical history, consultations, medicines or Treatment and copies of all Hospital and/or medical records.

This authorization also permits the Company to recover from any insurance carrier, entity or Government Health Insurance Plan (GHIP), payments that were made on my behalf for such services. A photostatic or facsimile copy of this Authorization and Release will be as valid and effective as the original.

I, Applicant 1, hereby appoint____________ to act on my behalf in the event that, because of a medical condition, I am unable to make the necessary decisions with respect to my health status.

I, Applicant 2, hereby appoint____________ to act on my behalf in the event that, because of a medical condition, I am unable to make the necessary decisions with respect to my health status.

APPLICANT 1 SIGNATURE DATE

APPLICANT 2 SIGNATURE DATE

INSURER'S COPY