TRANSAT MEDICAL QUESTIONNAIRE
Effective August 2020

UNDERWRITTEN BY
THE MANUFACTURERS LIFE INSURANCE COMPANY (MANULIFE)

This Medical Questionnaire is required for **applicants age 60 or older** applying for the **Emergency Medical Plan**, the **Annual Medical Plan** or the **Annual All-Inclusive Plan**. Answers to this Transat Medical Questionnaire will determine if you are eligible to purchase this insurance and, if you are eligible, to determine the plan you qualify for.

It is your responsibility to understand your coverage. If you have questions, call 1 800 263-2356.

INSTRUCTIONS TO APPLICANT

1
You must answer all questions completely and correctly. Your medical history will be reviewed at the time of a claim and if **any of your answers** are found to be incomplete or incorrect, **your coverage will be null and void (even if the incorrect answer is not related to the claim reported).**

2
If you have any doubt about your *medical condition* as it relates to the questions asked, you must consult your physician for advice to make sure your answers are correct.

3
Only **you**, the applicant, can complete and sign your Transat Medical Questionnaire. Your spouse or agent cannot assist you in the completion of this document.

4
Please note that the Transat Medical Questionnaire will not be accepted if there are mistakes (mistakes cannot be initialed) or if additional information is written on it.

ELIGIBILITY REQUIREMENTS

You are **not eligible to purchase this insurance** if:

1. You have been advised by a physician **not to travel** at this time;
2. You have **ever** had or you are **waiting** for a **bone marrow** or **organ transplant** (excluding corneal transplant);
3. In the last **12 months**, you have required **kidney dialysis**;
4. In the last **12 months**, you have been prescribed or used **home oxygen**;
5. In the last **2 years**, you have been diagnosed with a **terminal illness** for which a physician has estimated that you have less than **6 months** to live.

If **any** of the statements above **applies to you**, **you are not eligible to purchase this insurance**. Please do not complete the Medical Questionnaire on Page 2. If **none** of the statements above **apply to you**, please continue.

INDIVIDUAL MEDICAL UNDERWRITING

If **none** of the statements in the **Eligibility Requirements** section apply to you and you would like to have **your *pre-existing condition(s)*** covered, please call **1-855-857-5921 for Individual Medical Underwriting**. You may be provided with a quote for a **Single-Trip Emergency Medical Plan and have your *pre-existing conditions* covered**.

If you do not wish to apply for Individual Medical Underwriting, please complete the Medical Questionnaire on Page 2. **A *pre-existing condition* exclusion may apply to you**.

DEFINITIONS

Change in Medication means the medication dosage, frequency or type has been reduced, increased, or stopped or new medication(s) has/have been prescribed. **Exceptions:** the routine adjustment of Coumadin, warfarin or insulin (as long as they are not newly prescribed or stopped) to test your blood levels; and a change from a brand-name medication to a generic brand medication of the same dosage.

Heart Condition means **any** disorder relating to your heart.
Heart conditions include but are not limited to the following:

- An abnormal cardiac test result
- Atrial fibrillation
- Chest pain or discomfort due to the heart, or angina
- Heart failure or heart attack, or myocardial infarction, or cardiac arrest
- Heart murmur (Does not include a murmur that existed as a child if the physician has advised that there is no murmur as an adult)
- Narrowing or blockage of a coronary artery, or coronary artery disease
- Prior heart surgery of any kind, including but not limited to angioplasty, bypass surgery, valvuloplasty, valve replacement, heart ablation surgery, heart transplantation or surgery for any congenital heart disorder
- Any heart valve disorder, or any rapid, or slow, or irregular heartbeats or heart rates for which a physician has prescribed medication, or for which there has been surgery or cardioversion
- *Treatment* with a pacemaker or a cardiac defibrillator device
- Water on the lungs or swelling of the ankles due to a heart disorder

Medical condition(s) means any disease, sickness or injury (including symptoms of undiagnosed conditions).

Pre-existing condition(s) means a *medical condition* that existed before the effective date.

Stable means a *medical condition* is considered *stable* when all of the following statements are true:

1. there has not been any new *treatment* prescribed or recommended, or change(s) to existing *treatment* (including a stoppage in *treatment*), and
2. there has not been any *change in medication*, or any recommendation or starting of a new prescription drug, and
3. the *medical condition* has not become worse, and
4. there has not been any new, more frequent or more severe symptoms, and
5. there has been no hospitalization or referral to a specialist, and
6. there have not been any tests, investigation or *treatment* recommended, but not yet complete, nor any outstanding test results, and
7. there is no planned or pending *treatment*.

All of the above conditions must be met for a *medical condition* to be considered *stable*.

Treat, ***Treated*** or ***Treatment*** means hospitalization, a procedure prescribed, performed or recommended by a physician for a *medical condition*. This includes but is not limited to prescribed medication, investigative testing and surgery. **Important:** Any reference to testing, tests, test results, or investigations excludes genetic tests. "Genetic test" means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.

NOTICE ON PRIVACY AND CONFIDENTIALITY

The specific and detailed information requested on the application form is required to process the application. To protect the confidentiality of this information, Manulife will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife employees, mandataries, administrators or agents who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Manulife, P.O. Box 1602, Waterloo, Ontario N2J 4C6. You may also visit Manulife at https://www.manulife.ca/privacy-policies.html for further details about our Privacy Policy.

Accessible formats and communication supports are available upon request. Visit Manulife.ca/accessibility for more information.

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transat

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Effective August 2020

UNDERWRITTEN BY
THE MANUFACTURERS LIFE INSURANCE COMPANY (MANULIFE)

Last Name, First Name		User ID/ Agent Code	Transat Agency Code	Policy Number	Date of Birth (MM/DD/YYYY)
HOME ADDRESS Street	Apt. No.	City		Province	Postal Code
Home Phone No. ( )	Work Phone No. ( )	E-mail (optional)	Country of Destination		Phone No. at Destination

SECTION 1 AGREEMENT, UNDERSTANDING AND AUTHORIZATION

Please read the following important statements carefully. Once you have read and understood the statements, please sign below and continue to complete this Transat Medical Questionnaire.

- I will personally complete this Transat Medical Questionnaire and all information disclosed on it is complete and correct. **I fully understand that if any of my answers are incomplete or incorrect, then any coverage offered will be null and void**. I understand that the answers on my Transat Medical Questionnaire are material to the risk and constitute the basis of my insurance application. Where I was unsure of my medical history as it relates to my Transat Medical Questionnaire, I have verified it with my physician.
- I confirm that I have read and understood the **Eligibility Requirements section on Page 1**, prior to completing my Transat Medical Questionnaire.
- I confirm that I have read and understood the **Instructions to Applicant, and Definitions sections on Page 1**, prior to completing my Transat Medical Questionnaire.
- I understand the **necessity of calling the Transat Travel Insurance Assistance Centre before seeking medical attention during my trip**. Information on how to contact the Transat Travel Insurance Assistance Centre is included in the policy and on the wallet card provided by Transat Travel Insurance.
- I understand Manulife, its agents, third-party administrators or its legal representatives may investigate any claim. I authorize any hospital, physician, other medical service provider, or any other organization or person that has any records or knowledge of me and my health to release to third-party administrators and/or Manulife and its reinsurers any such information for the purpose of this application and contract and any subsequent claim.

Applicant Signature X _____ Date Signed (MM/DD/YYYY) _____

SECTION 2

1. Have you **ever** **been diagnosed** with and/or had ***treatment*** and/or been in **hospital** and/or **been prescribed** and/or **taken** medication for **any** ***heart condition*** or **aneurysm?** ◯ NO ◯ YES
2. Have you **ever** **been diagnosed** with and/or had ***treatment*** and/or been in **hospital** and/or **been prescribed** and/or **taken** medication for **both** **diabetes** and a **stroke**? ◯ NO ◯ YES
3. In the last **5 years**, have you **been diagnosed** with and/or had ***treatment*** and/or been in **hospital** and/or **been prescribed** and/or **taken** medication for **metastatic cancer**? ◯ NO ◯ YES
4. In the last **12 months**, have you been prescribed or taken **Lasix** or **furosemide for any reason?** ◯ NO ◯ YES
5. In the last **12 months**, have you been **diagnosed with** and/or had ***treatment*** and/or been advised to see a **specialist physician** and/or **attended a specialty clinic** and/or been in **hospital** and/or been **prescribed** and/or **taken** medication for **any** of these medical conditions?

• **stroke** or **mini-stroke (TIA)** (including use of aspirin/Entrophen for this condition) or **narrowing or blockage of an artery in the leg(s)** (peripheral vascular disease)	◯ NO ◯ YES
• **diabetes** treated with insulin or medication	◯ NO ◯ YES
• **lung** condition (medications include any puffer(s)/inhaler(s); except a single unrepeated prescription used for a single episode)	◯ NO ◯ YES
• **cancer** (except basal cell and squamous cell skin cancer, and breast cancer treated only with hormonal therapy)	◯ NO ◯ YES
• **liver** disorder or **pancreatitis** or **gallbladder** disorder	◯ NO ◯ YES
• **kidney** disorder (excluding stones)	◯ NO ◯ YES
• **gastrointestinal disease** or **gastrointestinal bleeding** or **bowel obstruction** or **bowel surgery** or **chronic bowel** disorder	◯ NO ◯ YES

If you answered **Yes** to **any** question(s) in **Section 2**, **you are not eligible to purchase this insurance. Please call 1-855-857-5921 for Individual Medical Underwriting. You may be provided with a quote for a Single-Trip Emergency Medical Plan and have your *pre-existing conditions* covered**.

If you answered **No** to **all** the questions in **Section 2**, initial here and please continue to answer the questions in **Section 3** below. → Initial _____

SECTION 3

1. In the last **2 years**, have you used **any** **tobacco product**? ◯ NO ◯ YES
2. Was your last **regular check-up** with a physician more than **18 months** ago? ◯ NO ◯ YES
3. **For high blood pressure (same as hypertension)**:
   a) Are you **currently** taking medication to *treat* or prevent **high blood pressure**? ◯ NO ◯ YES
   b) Have you been prescribed medication to *treat* or prevent **high blood pressure** and chosen not to take it? ◯ NO ◯ YES
4. In the last **12 months**, have you **taken prescription medication** and/or **received** other ***treatment*** for **arthritis** or **osteoporosis**? ◯ NO ◯ YES

Please initial beside the Plan and Exclusion that applies to you based on your answers to the questions in Section 3.

If you answered **Yes** to **any** question(s) in **Section 3**, you qualify for **Plan A**. **We will not pay** any expenses relating to a ***pre-existing condition*** or related *medical condition* which was **not *stable*** during the **3-month** period before your effective date. → Plan A Initial _____

If you answered **No** to **all** the questions on the entire Medical Questionnaire, you qualify for **Plan A+** and **no *pre-existing condition* exclusion** applies to you. → Plan A+ Initial _____

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