Application

ELITE U.S. Healthcare™

For Head Office Use Only

34 09 APP ECA 0110 000

.: Important Instructions

All sections must be completed in full. Incomplete forms will be returned to sender for completion and re-submission.

The Authorization Form is a mandatory requirement to be submitted by the Proposed Insured Person or, in the case of a minor, by the Proposed Policyholder on behalf of the Proposed Insured Person.

If more space is required, please attach additional pages, indicating you have done so in the appropriate section.

Completed Applications must be hand delivered, mailed or sent by courier to:

illnessPROTECTION.com Inc.
Attn: ELITE U.S. Healthcare™ Applications
600 Cochrane Drive, Suite 210
Markham, Ontario
L3R 5K3

.: Section 1 - Privacy Statement

Your personal information is collected for the purpose of providing you with insurance services, claims analysis and payments.

For Privacy Information, please see www.rsagroup.ca, or call us at 1-800-716-4339.

You may request a review of your file at any time. Please submit your written request to:

Global Excel Management Inc.
Privacy Officer
73 Queen Street
Sherbrooke, QC J1M 0C9

.: Section 2 - Proposed Insured Person Information

PLEASE PRINT:

Last Name: | First Name & Initial:

Street Address: | Apt. No. : | P.O. Box, R.R.:

City: | Province: | Postal Code:

Home Telephone: | Email:

Employer: | Occupation:

Business Address:

City: | Province: | Postal Code:

Business Telephone:

Sex: ❑ Male ❑ Female Date of Birth (D/M/Y): Language Preference: ❑ English ❑ French

Marital Status: ❑ Married ❑ Single ❑ Divorced / Separated ❑ Widow(er)

.: Section 3 - Proposed Policyholder Information (if other than Proposed Insured Person)

Proposed Policyholder:

Plan Administrator (if applicable) - please print name:

Street Address: | Suite No.:

P.O. Box, R.R.:

City : | Province: | Postal Code:

Business Telephone:

.: Section 4 - Evidence of Insurability

The following information is admitted as evidence of your insurability and as a condition of the medical underwriting process.*

Further medical testing may be required, however that will be evaluated once the initial data is complete.

If coverage is requested for a Proposed Insured Person who is a minor, all questions and requests for additional information must be directed to a parent or legal guardian as a condition to the medical underwriting process.

All Proposed Insured Persons who have reached the age of majority must submit their own Evidence of Insurability.

In order to determine age of majority with respect to the Evidence of Insurability, please refer to the following chart:

Age of Majority by Province or Territory	
Age	Province or Territory
18	AB, MB, ON, PE, QC, SK
19	BC, NB, NL, NS, NT, NV, YT

* Note: All Proposed Insured Persons must submit to the underwriting process and provide written authorization that they understand and willingly consent to and participate in this process, as outlined in the Authorization From to be submitted with this Application.

Any "Yes" responses may require follow-up questions and/or medical testing. Please complete the name and telephone details of the individual to whom these questions should be directed in the space provided.

Name of Parent, or Legal Guardian to be contacted: | Telephone: ( )

Name of family physician: | Telephone: ( )

Address:

IMPORTANT: Provide details to any "Yes" answer(s) on page 4.

Height: _____ **Weight:** _____ **Waist size:** _____ **Waist size at umbilicus:** _____

1. When was your last annual medical check-up?

a) Date: _____ b) Results: _____

2. Have you ever had an application for health or life insurance declined, cancelled or modified in any way? ❑ Yes ❑ No

If yes: a) Type of insurance: _____

b) Reason: _____

c) Year: _____

3. Do you presently have a medical condition, or are you presently receiving treatment, under prescription and/or taking medication? ❑ Yes ❑ No

4. Do you have any physical or mental impairment, congenital or otherwise? ❑ Yes ❑ No

5. Are you presently on a waiting list for investigations, a surgical procedure or any treatment? ❑ Yes ❑ No

Have you ever had any diagnosis, consultation, treatment, been prescribed and/or taken medication, been hospitalized for any of the following medical conditions:

6. Heart condition? ❑ Yes ❑ No

7. Stroke (CVA), mini-stroke (TIA), epilepsy, headaches or other nervous system disorder? ❑ Yes ❑ No

8. Hypertension? If yes, provide blood pressure levels*: ❑ Yes ❑ No

Date: _____ Systolic: _____ Diastolic: _____

9. High Cholesterol? If yes, provide cholesterol levels*: ❑ Yes ❑ No

Date: _____ Total cholesterol: _____ HDL-C: _____ LDL-C: _____

10. Any vascular conditions, i.e. involving arteries (such as peripheral vascular disease or aneurysm) or veins (such as phlebitis or thrombosis)? ❑ Yes ❑ No

11. Anemia or blood disorder? ❑ Yes ❑ No

12. HIV (Human Immunodeficiency Virus), any HIV related illness, or AIDS (Acquired Immune Deficiency Syndrome)? ❑ Yes ❑ No

13. Diabetes? ❑ Yes ❑ No

14. Thyroid or other glandular conditions? ❑ Yes ❑ No

15. Cysts, tumors or cancer? ❑ Yes ❑ No

16. Gastro-intestinal, liver, gallbladder, spleen or pancreas problems? ❑ Yes ❑ No

17. Kidney, bladder or other genito-urinary problems? ❑ Yes ❑ No

18. Asthma, chronic bronchitis, emphysema or other disease of the lung or respiratory system? ❑ Yes ❑ No

19. Back, neck, hip, knee or other joint disorder (i.e., arthritis, rheumatism, etc.)? ❑ Yes ❑ No

20. Eyes, ears, nose, throat or jaw problems? ❑ Yes ❑ No

21. Abnormal findings/studies? ❑ Yes ❑ No

22. Skin problems or conditions? ❑ Yes ❑ No

Within the past 10 years, for any reason not already disclosed, have you:

23. Been hospitalized or advised to be hospitalized? ❑ Yes ❑ No

24. Had surgery or been advised to have surgery? ❑ Yes ❑ No

25. Had any injury, illness, medical attention, medical advice or treatment? ❑ Yes ❑ No

26. Been advised to have any test which was not done? ❑ Yes ❑ No

* If unknown, this information will be obtained from your family physician.

Smoking, drinking and drug use:

27. Have you consumed tobacco products, in any form, in the past 3 years (cigarettes, pipe, cigars, cigarillos, chewing tobacco)? ❑ Yes ❑ No

If yes: a) Type of product: _____

b) Amount used: _____ /day _____ /week _____ /month _____ /year

c) Date last used: _____ d) End date (if applicable): _____

28. In the past 5 years, have you consumed alcoholic beverages? ❑ Yes ❑ No

a) If yes, average consumption : _____Beer (bottles/cans) / ❑ day ❑ week ❑ month

_____Wine (glasses) / ❑ day ❑ week ❑ month

_____Liquor (oz/ml) / ❑ day ❑ week ❑ month

b) Have you ever reduced your alcohol consumption? ❑ Yes ❑ No

c) Have you ever been treated or received advice for alcohol use? ❑ Yes ❑ No

d) Are you or have you been a member of a support group? ❑ Yes ❑ No

e) Have you ever had a relapse? ❑ Yes ❑ No

29. In the past 5 years, have you used unprescribed drugs or experimented with drugs, narcotics such as ecstasy, cocaine, LSD, heroin, amphetamines, barbiturates, anabolic steroids or similar agents? ❑ Yes ❑ No

If yes: a) What did you use? _____

b) Frequency: _____

c) Last time used: _____

Please list below all medications:
- **currently prescribed to you**
- **currently taken by you**
- **prescribed to you in the last 24 months**
- **taken by you in the last 24 months**

Please list any other medical conditions as well.

Please provide details to "Yes" answers. If more space is required, please complete and attach the Medical Questionnaire Supplement form.

Question	Illness/Impairment (Including all medications)	Date Diagnosed or Treated	Name, Address & Telephone # of Family Physician
#			
#			
#			
#			
#			
#			

.: Family Medical History

Mother - Name:

❑ Living ❑ Deceased Age (if deceased, age at time of death):

Medical Conditions (check if applicable): ❑ Heart Condition - Age at diagnosis: ❑ Diabetes - Age at diagnosis:

❑ Hypertension - Age at diagnosis: ❑ Cancer - Age at diagnosis: ❑ Other Hereditary Condition:

If other, please specify:

.: Family Medical History (continued)

Father - Name:

❑ Living ❑ Deceased Age (if deceased, age at time of death):

Medical Conditions (check if applicable): ❑ Heart Condition - Age at diagnosis: ❑ Diabetes - Age at diagnosis:

❑ Hypertension - Age at diagnosis: ❑ Cancer - Age at diagnosis: ❑ Other Hereditary Condition:

If other, please specify:

Sibling #1 - Name: ❑ Male ❑ Female

❑ Living ❑ Deceased Age (if deceased, age at time of death):

Medical Conditions (check if applicable): ❑ Heart Condition - Age at diagnosis: ❑ Diabetes - Age at diagnosis:

❑ Hypertension - Age at diagnosis: ❑ Cancer - Age at diagnosis: ❑ Other Hereditary Condition:

If other, please specify:

Sibling #2 - Name: ❑ Male ❑ Female

❑ Living ❑ Deceased Age (if deceased, age at time of death):

Medical Conditions (check if applicable): ❑ Heart Condition - Age at diagnosis: ❑ Diabetes - Age at diagnosis:

❑ Hypertension - Age at diagnosis: ❑ Cancer - Age at diagnosis: ❑ Other Hereditary Condition:

If other, please specify:

Sibling #3 - Name: ❑ Male ❑ Female

❑ Living ❑ Deceased Age (if deceased, age at time of death):

Medical Conditions (check if applicable): ❑ Heart Condition - Age at diagnosis: ❑ Diabetes - Age at diagnosis:

❑ Hypertension - Age at diagnosis: ❑ Cancer - Age at diagnosis: ❑ Other Hereditary Condition:

If other, please specify:

Note: If you have more than three siblings, please complete the Additional Sibling Information form and attach.

.: **Section 5 -** Plan Selection

Please check the deductible level you have selected:

❑ $5,000 USD ❑ $10,000 USD

.: Section 6 - Declarations and Signatures

The Proposed Insured Person hereby requests that Global Excel Management Inc. (hereafter "Global Excel"), on behalf of Royal & Sun Alliance Insurance Company of Canada, issue an ELITE U.S. Healthcare™ insurance policy based on the statements and representations stated throughout the application process. Furthermore, the Proposed Insured Person hereby declares the statements and answers provided throughout this application process to be complete and true and agrees that such statements and answers shall constitute the application for and form part of the insurance contract and that the insurance shall become effective in accordance with and subject to the terms and conditions of the policy to be issued to the Proposed Insured Person, but in no case shall it become effective until the application has been approved by the Insurer and the Proposed Insured Person has paid the first premium payment. The Proposed Insured Person further agrees that no statement in this application shall be binding upon Global Excel nor modify the aforesaid company's rights.

Should the Proposed Insured Person's insurability as a health risk change by any event or circumstance between the date of the original application and the effective date of the policy, the Proposed Insured Person must immediately notify Global Excel.

The Proposed Policyholder understands that the Insurer may exercise its right to void any policy in the event of nondisclosure or misrepresentation in the Evidence of Insurability.

In case of errors or omissions discovered by the Insurer in this application, the Insurer is hereby authorized to amend this application by noting the changes in the section entitled Corrections and Modifications and acceptance by the Proposed Insured Person of the policy accompanied by a copy of this application so amended, shall constitute a ratification of such corrections and modifications.

The Proposed Policyholder agrees the insurance will become effective only when the following conditions have been satisfied:

1. Global Excel has approved, at its head office, this application and the Effective Date of the contract; and

2. The first annual premium remittance has been provided to Expert Travel Financial Security (E.T.F.S.) Inc.

Claims in process on the effective date of the insurance will not be assumed by the Insurer. Current coverage should not be cancelled until this application has been approved by Global Excel.

The Proposed Policyholder consents to any changes being made to the insurance policy, as required under the applicable laws, regulations and/or guidelines.

Signed at _____ on this _____ day of _____ , 20_____

Signature of Proposed Insured Person: _____ Name of Witness: _____

Authorized signature of Proposed Policyholder: _____ Signature of Witness: _____
(if other than Proposed Insured Person)

.: Section 7 - Agency/Producer Information (for completion by the agency/producer)

MGA Name (please print): illnessPROTECTION.com Inc. | MGA Number: 5519

Complete Address: 600 Cochrane Drive, Suite 210, Markham, Ontario L3R 5K3

Signature: _____ | Date (D/M/Y): _____

.: Section 8 - For Head Office Use Only

Corrections and Modifications

_____

_____

Authorized by	Date (Day/Month/Year)

Underwritten by:

RSA

Administered by:

GlobalExcel®

Authorization Form

ELITE U.S. Healthcare™

Important Instructions

All Proposed Insured Persons must complete this Authorization Form and submit it along with their ELITE U.S. Healthcare™ application. Authorization of sections A, B, C and D is mandatory for submission as part of the application process. Incomplete forms will be returned to sender along with the application for completion and re-submission. ***This authorization will be valid until revoked by written notice to Global Excel Management Inc. (hereafter "Global Excel").***

Name of Proposed Insured Person (please print) Date of birth (D/M/Y)

Name of parent or legal guardian, if applicable (please print)

.: A - Eligibility

I hereby attest that as a condition to eligibility, I am a Canadian citizen or hold landed immigrant status. I am covered under the government health insurance plan of my province or territory of residence, and have permanent principal residence in Canada.

.: B - Authorization of evidence of insurability administration

I understand that Evidence of Insurability is required for the assessment of insurance risk and underwriting purposes and will be disclosed as described in my Application for insurance. Furthermore, I understand that this information will be collected for the purpose of evaluating my eligibility to purchase the plan and kept in an ELITE U.S. Healthcare™ file by Global Excel, to be held securely for the administration of the product for as long as it remains in effect and for up to seven (7) years following termination.

.: C - Authorization for disclosure of information to agency / producer / plan administrator

By signing this Authorization Form, I hereby direct and authorize Global Excel, to furnish to my agency / producer / plan administrator (as named in my Application for insurance) any or all information with respect to my Application for insurance and medical underwriting process.

I understand that all information will be provided to my agency/producer/plan administrator for relay to me in the normal course of business activities resulting from my Application for insurance.

.: D - Authorization for release of personal information

By signing this Authorization Form, I hereby direct and authorize any physician, health care practitioner, hospital or other medical care facility, pharmacy, the Ministry of Health, any insurance company, the Medical Information Bureau or any other person who has attended and examined me or who has knowledge or records of me or my health, to furnish to Royal & Sun Alliance Insurance Company of Canada and to Global Excel any or all information with respect to my sickness, injury, medical history, consultations, medicines or treatment and copies of all hospital or medical records. Such information will be provided for the assessment of insurance risk for underwriting purposes; investigations necessary to adjudicate any claim or to assess the validity of the policy as issued. I understand that if I refuse to provide this Authorization, Global Excel will be unable to assess the insurance risk and therefore unable to issue a policy or adjudicate a claim, whatever the case may be. A photocopy of the signed Authorization to obtain this information will be as legally valid as the original.

.: E - Signature of applicant / parent / legal guardian

I hereby understand and submit to all conditions of application for ELITE U.S. Healthcare™ as stipulated in sections A, B, C, and D, above.

Signature of Proposed Insured Person / parent / legal guardian Date (D/M/Y)

Signature of witness Date (D/M/Y)