

## Detailed medical questionnaire

Underwritten by CUMIS General Insurance Company, a member of The Co-operators group of companies, and administered by Allianz Global Assistance. Allianz Global Assistance is a registered business name of AZGA Service Canada Inc.

**How to complete this form:** Complete one form for each person applying for insurance.

- Answer all questions on the form.
- If you're unsure about your answers, please talk to your physician first.
- Applicant, legal guardian or power of attorney must sign and date the form.
- If you have any questions about this form, you can reach us toll-free at: 1-888-298-8151.
- If your application is missing information or isn't signed and dated, we'll have to follow up with you or your agent/broker and it will take longer to process your application.

For the complete terms, conditions, limitations and exclusions please refer to the policy.

**Mail, fax or email it back to us**

**AZGA Service Canada Inc.**  
o/a Allianz Global Assistance  
Underwriting Department  
250 Yonge Street, Suite 2100  
Toronto, Ontario M5B 2L7  
Canada

Fax: **1-866-256-2377** or 416-340-0790

Email: [directuw@allianz-assistance.ca](mailto:directuw@allianz-assistance.ca)

## Eligibility

1. Coverage is NOT AVAILABLE to any individual who, as of the effective date:
  - a) has been diagnosed with a terminal illness; or
  - b) has been diagnosed with or has had an episode of congestive heart failure; or
  - c) has had their most recent heart surgery more than 10 years ago; or
  - d) has been diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV); or
  - e) has been diagnosed with stage 3 or 4 cancer, or cancer of the lung, liver, pancreas, or bone; or has received treatment for any cancer (other than basal or squamous cell skin cancer or breast cancer treated only with hormone therapy) in the past 3 months; or
  - f) has had a lung condition for which, in the last 12 months, they have been prescribed or used home oxygen; or
  - g) has received or is awaiting a bone marrow or major organ transplant; or
  - h) has been diagnosed with or received treatment for kidney disease requiring dialysis; or
  - i) has been diagnosed with an aneurysm that has not been repaired; or
  - j) requires assistance with activities of daily living.

You are eligible to apply for coverage if you meet the eligibility requirements stated.

**Do you confirm that you are eligible to apply?**  NO  YES

## Information about you

Last name (please print)		First name	Date of birth	
MM/DD/YYYY				
Previous Allianz Global Assistance policy #'s (if known)				
Street		Apt #	City	
Province	Postal code	Phone	Fax	E-mail

## Information about your agent—Only complete this section if you have an agent

**Who should we contact?**  you  your agent

**MEDI-QUOTE INSURANCE BROKERS INC.**

Agent's name

Agent's code

**Send correspondence by**

Fax  E-mail

**info@mediquote.ca**

Attention

Ready to begin?  
Please go to the next page to get started.



Applicant's name (please print) _____	MM/DD/YYYY Date _____
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## Details about your travel plans

Destination (city, state or country) _____	MM/DD/YYYY Departure date _____	MM/DD/YYYY Return date _____
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### What type of coverage do you want?

#### Canadian Expatriates Plan

- Standard \$100,000
- Enhanced \$500,000
- Deluxe \$2,000,000
- Non-USA/Mexico
- Worldwide
- Occupation: \_\_\_\_\_

#### Inpatriates to Canada Plan

- \$100,000
- \$150,000
- \$200,000

## Your medical Information

1. Have you smoked or used any tobacco products in the last 5 years?  NO  YES
2. When was the last visit to your physician or medical clinic? (MM/DD/YYYY)

Height \_\_\_\_\_  ft/ in  cm

Weight \_\_\_\_\_  lbs  kg

**Reason for visit/Results** (diagnosis, medications prescribed, follow-up appointments, investigations or treatments, surgery recommended or scheduled)

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3. Have you been advised by a physician to have a test, investigation or surgery that you haven't had yet?  
 NO  YES → please provide details

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## Your medical conditions—Check YES or NO for each group of conditions

Check YES if you've **ever** had symptoms, investigations or treatment for any of the conditions in the group, then check the box beside the specific condition you have. If you have more than one condition, check the box for **every** condition that you have.

### Auto-immune disorder

NO  YES – please check all that apply

- Lou Gehrig's disease

- scleroderma
- acquired immune deficiency (AIDS) or human immunodeficiency virus (HIV)
- multiple sclerosis

- systemic lupus erythematosus
- sarcoidosis any location
- myasthenia gravis
- other \_\_\_\_\_

### Blood disorder

NO  YES – please check all that apply

- idiopathic thrombocytopenic purpura (ITP)

- hemochromatosis
- sickle-cell anemia
- anemia
- thrombophilia (hypercoagulability)

- hemophilia (hypocoagulability)
- spleen removed
- other \_\_\_\_\_

### High blood pressure, cholesterol or water retention

NO  YES – please check all that apply

- high blood pressure
  - not taking medication

- ➔ taking medication
  - 1  2  3+ medications
- high cholesterol
  - not taking medication
- ➔ taking medication
  - 1  2  3+ medications

- treated for water retention or edema in the last 12 months
- other \_\_\_\_\_

Please continue to the next page to tell us about symptoms, investigations and treatments. ▶



Applicant's name (please print)

Date

**Diabetes** NO  YES – please check all that apply

- pre-diabetes  
 diet-controlled diabetes

- type 1 diabetes (insulin)  
 type 2 diabetes (oral medication)  
 chronic kidney failure  
 diabetic neuropathy  
 skin infection (in last 30 days)

- lung infection (in last 30 days)  
 diabetic retinopathy  
 other \_\_\_\_\_

**Blood Vessels** NO  YES – please check all that apply

- aneurysm  
 ➤ repaired?  NO  YES  
 ➤ location:  
 abdominal  brain  
 thoracic  heart

- atherosclerosis  
 angina  
 phlebitis (vein inflammation)  
 peripheral vascular disease (PVD)  
 deep vein thrombosis (DVT)  
 thrombophlebitis

- varicose veins  
 ➤ surgery?  NO  YES  
 other \_\_\_\_\_

**Lung Condition** NO  YES – please check all that apply

- chronic obstructive pulmonary disease (COPD)  
 emphysema

- asthma  
 no medication  
 prednisone  
 inhaler  
 bronchitis  
 3 or more episodes in last 24 months

- tuberculosis  
 pulmonary fibrosis  
 use of home oxygen  
 other \_\_\_\_\_

**Heart** NO  YES – please check all that apply

- cardiomyopathy  
 chest pain or angina  
 prescribed and/or used any form of nitroglycerin (spray, patch, pill)  
 heart attack  
 ➤ How many have you had?  
 1  2  3+  
 cardiac or heart surgery

- What type of surgery?  
 balloon angioplasty  
 stent angioplasty  
 coronary artery bypass graft  
 ➤ How many arteries were grafted?  
 1  2  3  4  
 3 or more bypass operations  
 heart valve problem  
 heart valve surgery  
 balloon valvuloplasty  
 stent valvuloplasty  
 valve replacement

- irregular heart beat or rate (arrhythmia, bradycardia, tachycardia, atrial fibrillation, palpitations)  
 on medication  
 pacemaker inserted  
 external defibrillator  
 internal defibrillator  
 ablation  
 heart murmur  
 congestive heart failure  
 coronary artery disease  
 other \_\_\_\_\_

**Stroke / TIA** NO  YES – please check all that apply

- stroke  
 ➤ How many have you had?  
 1  2  3+

- require any assistance with activities of daily living  
 transient ischemic attack (TIA) or mini-stroke  
 ➤ How many have you had?  
 1  2  3+  
 endarterectomy (surgery on your carotid arteries)

- prescribed blood thinner (for example Warfarin, Coumadin)  
 before stroke  
 after stroke  
 other \_\_\_\_\_

**Muscle / Skeletal** NO  YES – please check all that apply

- arthritis  
 rheumatoid arthritis

- osteoporosis, osteopenia  
 degenerative disc disease (DDD)  
 fibromyalgia  
 herniated disc, spinal stenosis

- sciatica  
 scoliosis  
 spondylosis  
 other \_\_\_\_\_

Please continue to the next page to tell us about symptoms, investigations and treatments. ►

Applicant's name (please print)

Date

**Stomach or bowel (intestine or colon) condition (including gallbladder, hernia, throat and liver)** NO  YES – please check all that apply**Gallbladder**

- gallbladder attack  
 gallstones  
 gallbladder removed

**Bowel/intestine or colon**

- celiac disease

- inflammatory bowel disease (Crohn's disease, ulcerative colitis)  
 diverticulosis  
 diverticulitis  
 undiagnosed intestinal or rectal bleeding (not including hemorrhoids)  
 irritable bowel syndrome (IBS)

**Stomach**

- gastric bypass surgery  
 GERD, acid reflux or heartburn  
 gastritis  
 h. pylori

- hernia  
     ➤ repaired?  NO  YES  
 ulcer  
     ➤ repaired?  NO  YES

**Liver**

- liver disease  
 hepatitis  A  B  C  
 cirrhosis of the liver

**Throat**

- scleroderma, dysphagia, incoordination or achalasia

Other \_\_\_\_\_

**Kidney or urinary condition** NO  YES – please check all that apply

- kidney failure  
 2 or more urinary infections in last 12 months  
 protein in urine  
 kidney cysts

- kidney / bladder stones  
     ➤ How many times have you had stones?  1  2+  
 other \_\_\_\_\_

**Cancer** NO  YES – please check all that apply

## ➤ Location:

- brain  breast  bone  
 bowel, colon, intestine  
 Hodgkin's lymphoma  
 kidney  leukemia  
 liver  lung

- ovarian / cervical  
 prostate  bladder  
 skin  stomach  
 throat  
 other \_\_\_\_\_  
 cancer has spread to other organs of the body  
 inoperable  in remission  
 eliminated

- under treatment  
 chemotherapy  
 radiation treatment  
 hormone replacement treatment  
 surgery  
 watchful waiting  
 treatment is pending  
 treatment declined  
 other \_\_\_\_\_

**Uterine fibroids, ovarian cysts or prostate** NO  YES – please check all that apply

- uterine fibroid  
     ➤ surgery  NO  YES  
 hysterectomy  
 ovarian cyst  
     ➤ surgery  NO  YES

- benign prostatic hypertrophy (BPH)  
 on medication  
 surgery  
 other \_\_\_\_\_

**Nervous system conditions** NO  YES – please check all that apply

- anxiety / emotional disorder  
 Parkinson's disease  
 Guillain-Barre syndrome

- epilepsy or seizures  
 Alzheimer's disease  
 travelling alone  NO  YES  
 require any assistance with activities of daily living

- migraines  
 other \_\_\_\_\_

**Pregnancy**

If you are female, are you currently pregnant?

 NO  YES

If yes, what is your expected delivery date?

MM/DD/YYYY

Applicant's name (please print)

Date

Please tell us about the history of ALL of the medical conditions you checked on pages 2, 3 and 4. We need to know about your symptoms, any investigations, treatments and prescriptions you've had. Attach a separate sheet if necessary.

Medical condition	Medication	Date prescribed	Last dosage change	Symptoms/investigation/treatment and date
		MM/DD/YYYY	MM/DD/YYYY	
		MM/DD/YYYY	MM/DD/YYYY	
		MM/DD/YYYY	MM/DD/YYYY	
		MM/DD/YYYY	MM/DD/YYYY	
		MM/DD/YYYY	MM/DD/YYYY	

## Declaration

**You declare that:** The information you've provided in this questionnaire is truthful, complete and accurate.

**You understand that:**

- This questionnaire and the answers you provided are part of a contract provided through AZGA Service Canada Inc. o/a Allianz Global Assistance.
- If your medical status or any of your answers changes between the date you complete this questionnaire and your departure date or the effective date of any extension, you must contact Allianz Global Assistance prior to leaving on your trip to fully understand how your change in health affects the underwriting decision. Failure to do so may limit the amount of your claim payment or result in your claim being denied.
- The underwriting decision applies regardless of the sales medium and/or channel through which you purchase insurance. If a policy is issued to you that does not include this underwriting decision, it will be considered null and void, any premiums paid will be refunded

and no claims will be payable.

- Allianz Global Assistance will collect, use and/or disclose your personal information only to provide you with the insurance products and services you've requested, for other uses authorized by you, or as required by law.

**You acknowledge that:**

If you misrepresent your medical status in this questionnaire, or if you don't disclose material information about your medical status, or if any of your answers are found to be incorrect or untrue, your coverage will be null and void, your claims won't be paid and your premium will be refunded, even if the material non-disclosure or inaccuracy is not related to the claim reported, and you will be solely responsible for all expenses related to your claim.

This coverage is subject to exclusions, terms, conditions and limitations that may limit or exclude an amount payable.

## Authorization

**You authorize:** Any organization or person that has records or knowledge of your health to give any and all information<sup>1</sup> regarding your health, medical history and treatment to Allianz Global Assistance or its authorized representatives.

**You understand and agree that:**

- If you refuse or withdraw this authorization your application will be denied.
- A copy of this authorization and declaration is as valid as the original.

I HAVE READ AND UNDERSTOOD THE IMPORTANT INFORMATION IN THE STATEMENT ABOVE  NO  YES

You must sign and date this questionnaire or it will be returned to you.

Applicant's name (please print)

MM/DD/YYYY

Date

Signature

MM/DD/YYYY

Signature date

<sup>1</sup> **IMPORTANT:** Information 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.