IMPORTANT

Please fill this form in carefully.

Any incorrect answers may render your coverage null and void.

If you have questions, or are uncertain about your health history, consult with your Doctor.

This application contains eligibility requirements to determine if you qualify for insurance coverage.

Your Travel Agent is not permitted to help you fill out this Medical Questionnaire.

Underwritten by The Manufacturers Life Insurance Company (Manulife) and First North American Insurance Company (FNAIC), a wholly owned subsidiary of Manulife.

PLEASE READ THE IMPORTANT INFORMATION BELOW BEFORE YOU START

Instructions for completing this Medical Questionnaire.

You can only purchase this insurance if you meet ALL the Eligibility requirements at the top of page 2.

The Medical Questionnaire must be completed if you are **age 60 or older** and applying for an **Emergency Medical Plan or a Canada Medical Plan or an Annual Emergency Medical Plan or an Annual All-Inclusive Plan.**

- Only **YOU**, the applicant, can complete and sign this Medical Questionnaire. If you are uncertain about the accuracy of your answers to any of the medical questions, please ask your Doctor to verify those responses before completing this Medical Questionnaire.
- **Your medical history:** When answering the medical questions, your answers must be complete and accurate. **When adjudicating a claim, we will review your medical history. If any of your answers are found to be incorrect or incomplete, your coverage may be null and void.**
- **Your medical conditions:** If you have received anything from a medical professional, including investigation advice, a prescription, a diagnosis, any *treatment,* medication or hospitalization, take it into consideration when answering the medical questions.
- **Your prescriptions:** If you have taken a prescription medication or were prescribed a medication and you never filled the prescription or opened the bottle, please include it when answering the medical questions.
- **This application form consists of three pages:** this cover page, one page of questions that must be accurately completed and signed, and a page that includes some of the terms used, when italicized in the Medical Questionnaire.

Additional information to take into consideration regarding premiums (Smoker's Surcharge and Deductible Savings Options)

1 **Smoker's Surcharge:** If you are **age 60 or over**, your premium will be subject to a **10% surcharge** if, in the **last 2 years** prior to the date of purchasing your insurance coverage, you have:
- smoked cigarettes, and/or
- used vaping products, and/or
- used e-cigarettes.

2 **Deductible Savings Options:** These plans have $0 deductible. However, deductibles are offered to reduce your premium on the Emergency Medical Plan and the Annual Emergency Medical Plan. (Not available on the Annual All-Inclusive Plan or the Canada Medical Plan.)

Savings	Deductible Amounts ($ CDN) (per claim)
10%	$500
15%	$1,000
30%	$5,000
35%	$10,000

Please see page 3 of this form for terms used and *pre-existing condition* exclusions before completing this Medical Questionnaire.

It is your responsibility to read and understand the attached Medical Questionnaire in full.

It is your responsibility to understand your coverage. If you have questions, call 1 866 298-2722.

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

MGMED1119E-Rev.720 07/2020

Manulife

Manulife Global Travel Insurance
Medical Questionnaire

UNDERWRITTEN BY
THE MANUFACTURERS LIFE INSURANCE COMPANY (MANULIFE)
AND FIRST NORTH AMERICAN INSURANCE COMPANY (FNAIC),
A WHOLLY OWNED SUBSIDIARY OF MANULIFE

Name of Applicant (Last name, First name)	**Agent ID**	**Agency Code**	**Policy Number**	**Date of Birth** (MM/DD/YYYY)

Please read each question carefully and answer each question truthfully. Once you have completed this form and the questions have been answered truthfully, sign the Authorization and give it to your Travel Agent to send to us.

Declaration: I declare that all the information I am about to provide on this Medical Questionnaire shall be true and complete. I understand it is my responsibility to read the Manulife Global Travel Insurance policy and to understand its terms, conditions and exclusions including the *pre-existing condition* exclusion(s) that apply to my coverage. I understand that if I misrepresent any material information provided in this Medical Questionnaire, Manulife may void my policy and I will not be covered for any benefits under this policy.

I have read the above Declaration: (Signature)_____

Eligibility

1	Have you **been advised** by a physician **not to travel** at this time?	○ NO ○ YES
2	Have you **been diagnosed** with a terminal illness or metastatic cancer?	○ NO ○ YES
3	Do you **require** kidney dialysis?	○ NO ○ YES
4	In the last **12 months**, have you used or **been prescribed** home oxygen?	○ NO ○ YES
5	Have you had a bone marrow, stem cell or organ transplant (excluding cornea)?	○ NO ○ YES

STOP

If you answered **YES** to **ANY** of the above **ELIGIBILITY questions 1 through 5, you are not eligible to purchase this insurance.**	
If you have answered NO to ALL ELIGIBILITY questions, please proceed to Step 1.	**Initial**

Step 1.

1	Have you had a heart bypass, coronary angioplasty or heart valve surgery **more than 10 years ago**?	○ NO ○ YES
2	In the last **3 years**, have you been diagnosed with, taken or been prescribed medication, or been *treated* for **any 2 or more** of the following? (if you only have 1 of the following conditions, answer NO) • *Heart condition*; • Lung condition (except unrepeated prescription medications used for a single episode) (medication includes any puffer(s)/ inhaler(s)); • Stroke/CVA (cerebrovascular accident) or mini-stroke/TIA (transient ischemic attack) (medication includes use of aspirin/ Entrophen for this condition); • Diabetes (*treated* with medication and/or insulin); • Narrowed or blocked artery in the legs (also called Peripheral Vascular Disease).	○ NO ○ YES
3	In the last **2 years**, have you been:	
	a diagnosed with, taken or been prescribed medication, or been *treated* for heart failure or congestive heart failure;	○ NO ○ YES
	b prescribed or taken Lasix or furosemide or a water pill for ankle or leg swelling or water on the lungs?	○ NO ○ YES
4	In the last **12 months**, have you had:	
	a a new *heart condition*, or had an existing *heart condition* for which you had a *change in medication* or were hospitalized (as an inpatient or seen in the emergency department);	○ NO ○ YES
	b shortness of breath or chest pain for which you sought *treatment*;	○ NO ○ YES
	c a lung condition for which you were hospitalized (as an inpatient or seen in the emergency department) or for which you have been prescribed or taken prednisone;	○ NO ○ YES
	d cancer or received chemotherapy and/or radiotherapy and/or other *treatment*, other than routine follow-up, for cancer (except basal cell and squamous cell skin cancer, and breast cancer *treated* only with hormonal therapy)?	○ NO ○ YES
5	In the last **4 months**, have you been prescribed or taken **6 or more** prescription medications? **Do not count** the following medications: hormone replacement therapy (thyroid or menopausal); drugs used for osteoporosis, or traveller's diarrhea; or any form of immunization. **Do not count** topical medications that go in your nose, ears or eyes or on your scalp or skin **except** any form of nitroglycerine or any drug(s) for angina.	○ NO ○ YES

If you answered **YES** to **ANY of the questions 1 through 5 in Step 1, you are not eligible to purchase this insurance plan.** However, you may apply for Individual Medical Underwriting for a **Single Trip Emergency Medical Plan** that covers your *pre-existing conditions* by calling us at **1-877-882-2953**, toll free from Canada and the USA.

If you have answered NO to ALL the questions in Step 1, please answer the questions in Step 2 and Step 3. **Initial**

Step 2.

In the last **two (2) years,** have you smoked cigarettes and/or used vaping products or e-cigarettes?	○ NO ○ YES

Step 3.

1	Have you ever been diagnosed with or *treated* for:	
	a a *heart condition*;	○ NO ○ YES
	b any of the following conditions; • Aortic aneurysm (including thoracic or abdominal aneurysm) • Cirrhosis of the liver; • Parkinson's disease; • Alzheimer's disease or other form of dementia?	○ NO ○ YES
2	In the last **3 months**, have you been prescribed or taken a total of **3 or more** medications for high blood pressure (hypertension)?	○ NO ○ YES
3	In the last **5 years**, have you been diagnosed with, taken or been prescribed medication for, or been *treated* for any of the following:	
	a Lung condition (except unrepeated prescription medications used for single episode) (medication includes any puffer(s)/inhaler(s));	○ NO ○ YES
	b Stroke/CVA (cerebrovascular accident) or mini-stroke/TIA (transient ischemic attack) (medication includes use of aspirin/Entrophen for this condition);	○ NO ○ YES
	c Diabetes (if *treated* with medication and/or insulin);	○ NO ○ YES
	d Narrowed or blocked artery in the legs or in the neck?	○ NO ○ YES

Please initial beside the Plan and Exclusion that applies to you.

If you answered **YES** to **ANY questions in Step 3** and **NO** to **ALL questions in Step 1**, you qualify for **Plan C**. Refer to page 3 for details regarding the exclusions related to your *pre-existing condition* in the **6 months** before your effective date.	**Plan C** Initial
If you answered **NO** to **ALL questions in Step 3 and Step 1**, please answer the questions in **Step 4**.	**Initial**

Step 4.

1	In the last **2 years,** have you been diagnosed with, taken or been prescribed medication, or been *treated* for any of the following conditions:	
	a Gastrointestinal bleeding **or** bowel obstruction **or** have had bowel surgery;	○ NO ○ YES
	b Chronic bowel disorder (such as but not limited to Crohn's disease or Ulcerative colitis);	○ NO ○ YES
	c Kidney disorder (including stones) **or** Liver disorder **or** Pancreatitis;	○ NO ○ YES
	d Gallbladder disorder (including stones. Not applicable if gallbladder has been removed.)	○ NO ○ YES
2	In the last **2 years**, have you been diagnosed with, and/or *treated* by a Hematologist or an Internist for a blood disorder?	○ NO ○ YES
3	Are you **age 71 or over, AND** have you had a fall for which you sought medical attention in the last **6 months?**	○ NO ○ YES
4	In the **last 6 months**, have you received advice or *treatment* **3 or more times** in the emergency room of a hospital?	○ NO ○ YES

If you answered **YES** to **ANY questions in Step 4** and **NO** to **ALL questions in Step 3 and Step 1**, you qualify for **Plan B**. Refer to page 3 for details regarding the exclusions related to your *pre-existing condition* in the **6 months** before your effective date.	**Plan B** Initial
If you answered **NO** to **ALL questions in Step 4** and **NO** to **ALL questions in Step 3 and Step 1**, you qualify for **Plan A**. Refer to page 3 for details regarding the exclusions related to your *pre-existing condition* in the **3 months** before your effective date.	**Plan A** Initial

Authorization: I authorize any hospital, physician, other medical service provider or any other organization or person that has any records or knowledge of me or my health to release to Manulife, its agents, its third party administrators, its legal representatives and its reinsurers any such information for the purpose of this Medical Questionnaire and contract and any subsequent claim.

I apply to The Manufacturers Life Insurance Company (Manulife) for insurance under the Manulife Global Travel Insurance policy.

Signature	**Date signed (mm/dd/yyyy)**

Terms Used

Change in medication means the medication dosage, frequency or type has been reduced, increased or stopped, and/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 your heart, or angina
- Heart failure, or heart attack, or myocardial infarction, or cardiac arrest
- Heart murmur (Do not include a murmur you had as a child if your physician has advised that you do not have a 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 heart beats for which your physician has prescribed medication, or for which you have undergone surgery or cardioversion
- *Treatment* with a pacemaker and/or a cardiac defibrillator device
- Water on the lungs or swelling of the ankles due to a heart disorder

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

Pre-existing condition means a *medical condition* that existed before your effective date of insurance.

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.*

Treatment, treated 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.

Pre-existing condition exclusion

The *pre-existing condition* exclusion which applies depends on the Rate Category as determined by your answers to the medical questions on the reverse page.

Plan A

We will not pay any expenses relating to:

- a *pre-existing condition* that is not *stable* in the **three (3) months** before your effective date; and/or
- a *heart condition*, if, in the **three (3) months** before your effective date, any *heart condition* has not been *stable* or you have taken any form of nitroglycerine for the relief of angina pain; and/or
- a lung condition if, in the **three (3) months** before your effective date, any lung condition has not been *stable* or you required *treatment* with oxygen or prednisone for any lung condition.

Plan B and Plan C

We will not pay any expenses relating to:

- a *pre-existing condition* that is not stable in the **six (6) months** before your effective date; and/or
- a *heart condition*, if, in the **six (6) months** before your effective date, any *heart condition* has not been *stable* or you have taken any form of nitroglycerine for the relief of angina pain; and/or
- a lung condition if, in the **six (6) months** before your effective date, any lung condition has not been *stable* or you required *treatment* with oxygen or prednisone for any lung condition.

EXCEPTION: No *pre-existing condition* exclusion applies to the Canada Medical Plan.

FOR TRAVEL AGENT USE ONLY

Delivery Instructions:

Once this Medical Questionnaire is complete, please send the white copy to:

Manulife Global Travel Insurance
c/o Manulife
PO BOX 11009
STN CENTRE VILLE
MONTREAL, QC H3C 4T9

Please complete this section:

Company Name and Address	
Agent Name	E-mail Address
Telephone Number ( )	Fax Number ( )