MEDICARE INTERNATIONAL TRAVEL INSURANCE

Policy # ______________________

VERSION MØ8 MEDICAL QUESTIONNAIRE - AGE 55 OR OVER ONLY

Applicant 1 Name	Gender	Date of Birth	Applicant 2 Name	Gender	Date of Birth
PLEASE PRINT	❑ M ❑ F	MM/DD/YY	PLEASE PRINT	❑ M ❑ F	MM/DD/YY

ABOUT THE MEDICAL QUESTIONS – Medical questions help us to determine eligibility, access risk and determine the premium rate that is appropriate.
If you are uncertain of your answers to any of the medical questions, please consult your doctor before completing the application for insurance.

ELIGIBILITY

		Applicant 1	Applicant 2
1.	Have you been advised by a physician not to travel at this time?	❑ Yes ❑ No	❑ Yes ❑ No
2.	Do you require kidney dialysis?	❑ Yes ❑ No	❑ Yes ❑ No
3.	Have you **ever** had a bone marrow or organ transplant (excluding corneal transplant)?	❑ Yes ❑ No	❑ Yes ❑ No
4.	Have you had a heart bypass, angioplasty or heart valve surgery more than **ten (10) years** ago?	❑ Yes ❑ No	❑ Yes ❑ No
5.	In the last **five (5) years**, have you been diagnosed with and/or had treatment for metastatic cancer?	❑ Yes ❑ No	❑ Yes ❑ No
6.	In the last **six (6) months**, have you 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)?	❑ Yes ❑ No	❑ Yes ❑ No
7.	In the last **twelve (12) months**, have you been prescribed or taken Prednisone or oxygen or been hospitalized (as an in-patient or seen in the emergency department) for a lung condition?	❑ Yes ❑ No	❑ Yes ❑ No
8.	In the last **two (2) years**, have you: a) been prescribed or taken Lasix or furosemide for any reason? b) had congestive heart failure?	❑ Yes ❑ No	❑ Yes ❑ No
9.	In the last **twelve (12) months**, have you been hospitalized (as an in-patient or seen in the emergency department) for a heart condition?	❑ Yes ❑ No	❑ Yes ❑ No
10.	**In the last four (4) months**, have you been prescribed or taken **six (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 ears or eyes or on your scalp or skin **except:** any form of nitroglycerine or any drug(s) for angina.	❑ Yes ❑ No	❑ Yes ❑ No
11.	In the last **three (3) years**, have you been diagnosed with and/or had treatment for and/or been hospitalized (as an in-patient or seen in the emergency department) and/or been prescribed or taken medication for any **two (2)** of the following (If you only have **one (1)** of the following conditions, answer **NO**): • Heart condition • Lung condition (medication includes puffer(s)/inhaler(s) **except** a single unrepeated prescription used for a single episode) • Diabetes (treated with medication and/or insulin) • Stroke/CVA (cerebrovascular accident) or mini-stroke/TIA (transient Ischemic attack) including the use of aspirin/Entrophen for the condition • Peripheral vascular disease (blocked or narrowed arteries) • Alzheimer's disease, or any other form of dementia?	❑ Yes ❑ No	❑ Yes ❑ No

ELIGIBILITY REQUIREMENT. If you answered "YES" to ANY of the above questions, you are not eligible to purchase this insurance. DO NOT complete this application. Contact your agent/broker or 21st Century Travel Insurance to obtain a quote for the Individual Medical Underwriting Plan. If you answered "NO" to ALL of the above questions, you are eligible to purchase this insurance. Proceed to FIND YOUR RATE CATEGORY.

FIND YOUR RATE CATEGORY

Part 1 - Rate qualification

		Applicant 1	Applicant 2
1.	In the **last five (5) years**, have you been diagnosed with and/or had treatment and/or been hospitalized (as an in-patient or seen in the emergency department) and/or been prescribed or taken medication for **any** of the following: • Heart condition • Stroke/CVA (cerebrovascular accident) or mini-stroke/TIA (transient ischemic attack) including the use of aspirin/Entrophen for the condition • Aneurysm • Peripheral vascular disease (blocked or narrowed arteries) • Diabetes (treated with medication and/or insulin) • Lung condition (medication includes any puffer(s)/inhalers(s) **except** a single unrepeated prescription used for a single episode) • Cirrhosis of the liver • Alzheimer's disease, or any other form of dementia, or Parkinson's disease?	❑ Yes ❑ No	❑ Yes ❑ No
2.	In the last **five (5) years**, have you smoked or used tobacco products **and** been prescribed or used any puffer(s)/inhaler(s)?	❑ Yes ❑ No	❑ Yes ❑ No
3.	In the last **six (6) months**, have you received advice or treatment **more than once** in the emergency room of a hospital?	❑ Yes ❑ No	❑ Yes ❑ No
4.	In the last **three (3) months**, have you been prescribed or taken a total of **three (3) or more** medications for high blood pressure (hypertension) and/or a heart condition?	❑ Yes ❑ No	❑ Yes ❑ No

If you answered "YES" to ANY of the questions in Part 1, you qualify for Rate Category C. If you answered "NO" to ALL the questions in Part 1, proceed to Part 2.

Part 2 - Rate qualification

		Applicant 1	Applicant 2
1.	In the last **two (2) years**, have you been diagnosed with or received treatment for and/or been hospitalized (as an in-patient or seen in the emergency department) and/or been prescribed or taken medication for **any** of the following conditions:		
	• Bowel obstruction or surgery	❑ Yes ❑ No	❑ Yes ❑ No
	• Diverticular disorder requiring prescription medication or surgery	❑ Yes ❑ No	❑ Yes ❑ No
	• Gastrointestinal bleeding	❑ Yes ❑ No	❑ Yes ❑ No
	• Bleeding or perforated ulcer(s)	❑ Yes ❑ No	❑ Yes ❑ No
	• Chronic bowel disorder	❑ Yes ❑ No	❑ Yes ❑ No
	• Liver disorder	❑ Yes ❑ No	❑ Yes ❑ No
	• Pancreatic disorder	❑ Yes ❑ No	❑ Yes ❑ No
	• Kidney disorder (including stones)	❑ Yes ❑ No	❑ Yes ❑ No
	• Gall bladder disorder (including stones. If gall bladder has been removed, answer **NO**)?	❑ Yes ❑ No	❑ Yes ❑ No

If you have two (2) or more conditions listed in Part 2, you qualify for Rate Category C. If you have one (1) condition listed in Part 2, you qualify for Rate Category B. If you do not have ANY of the conditions listed in Part 2, proceed to Part 3.

Part 3 - Rate qualification

		Applicant 1	Applicant 2
1.	In the last **two (2) years**, have you been diagnosed with, and/or been hospitalized (as an in-patient or seen in the emergency department), and/or received treatment, and/or been prescribed medication by a Hematologist or an Internist for a blood disorder?	❑ Yes ❑ No	❑ Yes ❑ No
2.	In the last **twelve (12) months**, have you been prescribed or used a puffer/inhaler?	❑ Yes ❑ No	❑ Yes ❑ No
3.	In the last **twelve (12) months**, have you been diagnosed with or received treatment for cancer other than routine follow-up (**except** basal cell and squamous cell skin cancer, and breast cancer treated only with hormonal therapy)?	❑ Yes ❑ No	❑ Yes ❑ No
4.	Are you over 65, **and** have you had a fall that you reported to a physician in the last **six (6) months**?	❑ Yes ❑ No	❑ Yes ❑ No

If you answered "YES" to ANY of the questions in Part 3, you qualify for Rate Category B. If you answered "NO" to ALL of the questions in Part 3, proceed to Part 4.

Part 4 - Rate qualification

		Applicant 1	Applicant 2
1.	In the last **two (2) years**, have you smoked or used any tobacco products?	❑ Yes ❑ No	❑ Yes ❑ No

If you answered "YES" to the question in Part 4, you qualify for Rate Category A. If you answered "NO" to the question in Part 4, you qualify for Rate Category A+.

PLEASE READ CAREFULLY BEFORE SIGNING - I apply to the Manufacturer's Life Insurance Company (Manulife Financial) for insurance under the Medicare International Travel Insurance policy administered by 21st Century Travel Insurance Limited (o/a 21st Century Travel Insurance Services in British Columbia). I declare that all information I have provided on this application form and medical questionnaire (if required) is true and complete. I have read the Medicare International Travel Insurance policy and understand the terms, conditions and exclusions (including the pre-existing condition exclusion) that apply to my coverage. I understand that if I misrepresent any material information provided in this application, Manulife Financial will void my policy and I will not be covered for any benefit under this policy. I authorize any hospital, physician, other medical service provider or any other organization or person that has my records or knowledge of me or my health to release to the assistance and claims service provider appointed by Manulife Financial, and/or Manulife Financial and its reinsurers and/or 21st Century Travel Insurance Limited, any such information for the purpose of this application and contract and any subsequent claim.

Applicant 1 Signature: ______________________ **Applicant 2 Signature:** ______________________ **Date:** ______________________

AGENT: Please fax completed forms to 21st Century Travel Insurance Limited. **Toll-free Fax 1 866 285-5727**, within 3 business days of sale of policy.

FORM MMQ-1102