

Travel Choice 1 Travel Insurance

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

Call 1-866-943-5997, one of our representatives will be happy to assist you with the application by telephone.
Our office hours are 8:30 a.m. to 8:00 p.m. Monday to Friday, and 9:00 a.m. to 5:00 p.m. on Saturday (ET)

You can also apply online – No admin fee when you purchase online!

INSTRUCTIONS

All applicants, please refer to the Eligibility Section on Page 2

1. EMERGENCY MEDICAL PLANS:
Under age 60: Review Stability requirements on Page 4 and complete steps 2 through 5.
60 years of age or over: Please complete the Medical Declaration by answering yes or no to each question. If eligible, review Stability requirements on Page 4 and complete steps 2 through 5.
Non-Underwritten Plan: If your trip is less than 15 days, you can purchase the Non-Underwritten Plan. If applying for the Non-Underwritten Plan, do not complete the Medical Declaration section on this application.
2. The application and the Medical Declaration (if applicable) must be completed prior to the effective date of insurance.
3. If your health changes or does not remain stable² between the date the Medical Declaration was completed and submitted (if applicable) and the effective date, you must review the medical questions on the Medical Declaration with a sales agent at Vertis Insurance Solutions Ltd. (Vertis herein) to re-assess eligibility. **If you are no longer eligible for the insurance plan purchased and fail to contact Vertis, your claim will be denied, the Insurer will void your policy, and the premium paid will be refunded. This means no benefits will be covered and you will be responsible for all expenses relating to your sickness or injury, including repatriation costs.**
4. If purchasing a Multi-Trip Annual Plan and there is a change in your health status or your medical condition(s)⁴ does/do not remain stable² after you purchase this insurance, you may not be eligible for benefits under this policy if you submit a claim for that condition. SECTION II – INSURANCE AGREEMENT

PLAN INFORMATION

1. **Single Trip Daily Plan:** Provides coverage for a single trip while travelling outside your province or territory of residence for the entire duration of your trip.
2. **Multi-Trip Annual Plan:** Provides coverage for any number of trips, while travelling outside of Canada, up to the option you selected. This plan provides an unlimited number of days for travel within Canada (excluding your province or territory of residence). Trips must be separated by a return to your province or territory of residence or Canada.
3. **Canada Plan:** Provides coverage for a single trip while travelling outside your province or territory of residence **but within Canada** for the entire duration of your trip. You can benefit from great rates with a \$0 deductible. Please refer to the rate sheet for details.
4. **Non-Underwritten Plan:** Provides coverage for a single trip while traveling outside your province or territory of residence, up to 15 days. Available for applicants age 60 or over.
5. **40-day Supplemental Multi-Trip Annual Plan for the Public Service Health Care Plan (PSHCP) members:** Increase your coverage from \$500,000 to \$10 million CAD and be covered for Trip Cancellation, Interruption and Delay benefits up to \$4,000 CAD. Also be covered for benefits not offered by the PSHCP, such as Vehicle Return or Emergency Relief of Dental Pain from the first dollar. No Medical Questionnaire is required. See your policy for the full pre-existing condition exclusion.

DEFINITIONS

Please refer to the following definitions for words where notations 1 through 5 appear on this Application.

1. **Treatment/Treated** means hospitalization, prescribed medication (including prescribed as needed), medical, therapeutic, diagnostic or surgical procedure prescribed, performed or recommended by a licensed medical practitioner. 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.
2. **Stable** medical condition⁴ means that all of the following apply:
 - a) there has not been any new symptom(s); and
 - b) existing symptom(s) have not become more frequent or severe; and
 - c) a physician has not determined that the medical condition⁴ has become worse; and
 - d) no test findings have shown that the medical condition⁴ may be getting worse; and
 - e) a physician has not provided, prescribed, or recommended any new medication, any change in medication⁵; and
 - f) a physician has not provided, prescribed, or recommended any investigative testing, new treatment¹ or any change in treatment¹; and
 - g) there has been no admission to a hospital or referral to a specialty clinic or specialist; and
 - h) a physician has not advised a visit to a specialist or to have further testing, and there has been no testing for which the results have not yet been received.
3. **Minor Ailment** means a sickness or injury which does not require the use of medication for a period greater than 14 days, nor requires more than one follow-up visit to a physician, hospitalization, referral to a specialist, or surgical intervention and which ends at least 30 days prior to your departure date. However, a chronic condition or any complications thereof or a condition which require continuous and ongoing medical attention is not considered a minor ailment³.
4. **Medical Condition** means injury, sickness or symptom; complication of pregnancy within the first 31 weeks of pregnancy.
5. **Change in Medication** means the medication dosage, frequency or type has been reduced, increased, stopped and/or new medications(s) has/have been prescribed. **Exceptions:** the routine adjustment of Coumadin, warfarin or insulin (as long as they are not newly prescribed or stopped) and there has been no change in your medical condition⁴; and, a change from brand name medication to a generic brand medication of the same dosage.

ELIGIBILITY

1. You must meet the following conditions to be eligible for this insurance:
 - a) You must be a Canadian resident and be covered by the government health insurance plan of your Canadian province or territory of residence for the entire duration of your trip.
 - b) You have not been advised by a physician not to travel at this time.
 - c) You do not have a terminal illness for which a physician has estimated you have less than six (6) months to live.
 - d) You do not have metastatic cancer (a cancer that has spread from the original site to one or more other areas of the body).
 - e) You do not require kidney dialysis.
 - f) You have not been prescribed or used home oxygen in the last twelve (12) months.
 - g) You have not had a bone marrow, stem cell or organ transplant (excluding cornea transplant).
2. If you are applying for the **Non-Medical Travel Plan** the following eligibility conditions also apply:
 - a) You must be travelling on a covered trip of 365 days or less.
 - b) This insurance must be:
 - i. issued in Canada for travel arrangements booked through a supplier of travel services and for the entire duration of the covered trip;
 - ii. issued for the total amount of the non-refundable portion of the covered trip;
 - iii. purchased within 7 days of the initial deposit for your covered trip or prior to any cancellation penalties being applicable to you for the covered trip; and
 - iv. purchased prior to the contracted date of departure.
 - c) It is a condition precedent to the Insurer's liability under this policy that at the time of application:
 - i. You know of no reason for you, an immediate family member, a travel companion, or a travel companion's immediate family member, to seek medical attention;
 - ii. You and your travel companion(s) must be deemed fit to undertake and complete the covered trip as booked.

If the value of your covered trip exceeds \$20,000, prior approval from Vertis is required.

Note: If this insurance is purchased in any other manner than as stated in this Section, this policy shall be null and void and the Insurer's sole liability will be limited to the refund of this insurance premium paid.

STEP 1 — MEDICAL DECLARATION (for applicants age 60 or over)					
PART 1 – Medical Eligibility Requirements – Can I Purchase?		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 have a terminal illness for which a physician has estimated you have less than 6 months to live?	YES	NO	YES	NO
3.	Do you have metastatic cancer (a cancer that has spread from the original site to one or more areas of the body)?	YES	NO	YES	NO
4.	Do you require kidney dialysis?	YES	NO	YES	NO
5.	Have you been prescribed or used home oxygen in the last 12 months ?	YES	NO	YES	NO
6.	Have you had a bone marrow, stem cell or organ transplant (excluding corneal transplant)?	YES	NO	YES	NO
IMPORTANT: If you have answered YES to ANY of the questions in PART 1, you are not eligible to purchase this insurance.					
PART 2 – Plan Eligibility Requirements – What can I Purchase?		Applicant 1		Applicant 2	
7.	During the 24 months prior to your departure date, have you:				
	a) been diagnosed with or treated ¹ for heart failure?	YES	NO	YES	NO
	b) been prescribed or taken Lasix or furosemide for any reason?	YES	NO	YES	NO
8.	During the 12 months prior to your departure date, have you:				
	a) been diagnosed with or been hospitalized for a new heart condition, or had an existing heart condition which required hospitalization or a change in medication ⁵ ?	YES	NO	YES	NO
	b) had a lung condition (including pneumonia) which required hospitalization or treatment ¹ with Prednisone, (Deltasone or other generics)?	YES	NO	YES	NO
	c) had a diagnosis of or been treated ¹ for a total of 3 or more of the following medical conditions? <ul style="list-style-type: none"> • high blood pressure • stroke/cerebrovascular accident (CVA)/mini-stroke/transient ischemic attack (TIA) • heart condition (including a pacemaker) • diabetes (excluding diet controlled diabetes) • Alzheimer's disease or other form of dementia • lung condition (including any prescription for puffers/inhalers) excluding a minor ailment³ 	YES	NO	YES	NO
If you have answered YES to ANY of the questions in PART 2, you will require coverage other than this Insurance. Call 1-866-991-9104 toll free to discuss alternative coverage options. If you answered NO to ALL of the questions in PART 2, please continue with PART 3.					

PLAN QUALIFICATION REQUIREMENTS – What Rate Category Do I Qualify For?					
SMOKING STATUS		Applicant 1		Applicant 2	
	During the 5 years prior to your departure, have you smoked cigarettes?	YES	NO	YES	NO
If you have answered YES to the SMOKING STATUS question, you must add 10% of line 3, in STEP 5. If you answered NO do not add 10% of line 3, in STEP 5.					
PART 3		Applicant 1		Applicant 2	
9.	Have you had a heart bypass, angioplasty or heart valve surgery more than 10 years prior to your departure date? (Use the date of your most recent bypass, angioplasty or heart valve surgery.)	YES	NO	YES	NO
10.	During the 12 months prior to your departure date, have you been prescribed or taken 5 or more medications for any one or combination of the following medical conditions? <ul style="list-style-type: none"> • high blood pressure • stroke/cerebrovascular accident (CVA)/mini-stroke/transient ischemic attack (TIA) • heart condition (including a pacemaker) • diabetes (treated¹ with oral medication or insulin) • lung condition (including any prescription for puffers/inhalers) excluding a minor ailment³ 	YES	NO	YES	NO
If you have answered YES to ANY of the questions in PART 3, you qualify for Rate Category 1 . If you answered NO to ALL of the questions in PART 3, you must answer the questions in PART 4.					
PART 4		Applicant 1		Applicant 2	
11.	Have you been diagnosed with or treated ¹ for a heart condition (including a pacemaker) during the 10 years prior to your departure date?	YES	NO	YES	NO
12.	Have you been diagnosed with or treated ¹ for any of the following medical conditions during the 5 years prior to your departure date?				
	a) lung condition (including any prescription for puffers/inhalers) excluding a minor ailment ³	YES	NO	YES	NO
	b) stroke/cerebrovascular accident (CVA)/mini-stroke/transient ischemic attack (TIA)	YES	NO	YES	NO
	c) diabetes (treated ¹ with oral medication or insulin)	YES	NO	YES	NO
	d) narrowing or blockage of any artery or peripheral vascular disease	YES	NO	YES	NO
	e) Alzheimer's disease or other form of dementia	YES	NO	YES	NO
If you have answered YES to two or more questions in PART 4, you qualify for Rate Category 1 . If you have answered YES to any one question in PART 4, you qualify for Rate Category 2 . If you answered NO to ALL questions in PART 4, you must answer the questions in PART 5.					
PART 5		Applicant 1		Applicant 2	
13.	During the 12 months prior to your departure date, have you been diagnosed with or treated ¹ for cancer (excluding basal or squamous cell skin cancer or breast cancer treated ¹ only with Tamoxifen, Femara or Arimidex)?	YES	NO	YES	NO
If you have answered YES to the question in PART 5, you qualify for Rate Category 2 . If you answered NO to the question in PART 5, you must answer the questions in PART 6.					
PART 6		Applicant 1		Applicant 2	
14.	During the 5 years prior to your departure date, have you been diagnosed with or treated ¹ for any of the following medical conditions?				
	a) pancreatic disorder	YES	NO	YES	NO
	b) chronic bowel disease (such as, but not limited to: Crohn's disease, ulcerative colitis)	YES	NO	YES	NO
	c) bowel obstruction or bowel surgery	YES	NO	YES	NO
	d) gastrointestinal bleeding	YES	NO	YES	NO
	e) kidney disease (including stones)	YES	NO	YES	NO
	f) gallbladder disease (including stones) (if your gallbladder has been removed, answer NO)	YES	NO	YES	NO
	g) liver disease	YES	NO	YES	NO
	h) aneurysm	YES	NO	YES	NO
	i) cancer (excluding basal or squamous cell skin cancer or breast cancer treated ¹ only with Tamoxifen, Femara or Arimidex)	YES	NO	YES	NO
If you have answered YES to ANY of the questions in PART 6, you qualify for Rate Category 3 . If you answered NO to ALL of the questions in PART 6, you must answer the questions in PART 7.					

PART 7		Applicant 1		Applicant 2	
15.	Have you ever been diagnosed with or treated ¹ for any of the following medical conditions?				
	a) heart condition (including a pacemaker)	YES	NO	YES	NO
	b) lung condition (including any prescription for puffers/inhalers) excluding a minor ailment ³	YES	NO	YES	NO
	c) stroke/cerebrovascular accident (CVA)/mini-stroke/transient ischemic attack (TIA)	YES	NO	YES	NO
	d) diabetes (treated ¹ with oral medication or insulin)	YES	NO	YES	NO
	e) narrowing or blockage of any artery or peripheral vascular disease	YES	NO	YES	NO
	f) Alzheimer's disease or other form of dementia	YES	NO	YES	NO
16.	During the 12 months prior to your departure date, have you been diagnosed with or treated ¹ for high blood pressure?	YES	NO	YES	NO

If you have answered **YES** to **ANY** of the questions in PART 7, you qualify for **Rate Category 4**.
If you answered **NO** to **ALL** of the questions in PART 7, you must answer the questions in Part 8.

PART 8		Applicant 1		Applicant 2	
17.	During the 12 months prior to your departure date, have you been diagnosed with or treated ¹ for diabetes controlled only by diet?	YES	NO	YES	NO
18.	During the 12 months prior to your departure date, have you been diagnosed with or treated ¹ for high cholesterol?	YES	NO	YES	NO
19.	Has it been more than 24 months since your last regular check-up with a physician?	YES	NO	YES	NO

If you have answered **YES** to **ANY** of the questions in PART 8, you qualify for **Rate Category 5**.
If you answered **NO** to **ALL** of the questions in PART 8, you qualify for **Rate Category 6**.

STABILITY REQUIREMENT AND PRE-EXISTING CONDITION EXCLUSIONS		
For plans requiring a Medical Declaration – You must complete the Medical Declaration to determine which Rate Category you qualify for.		
If you qualify for:	Your Pre-existing Period is:	Your Pre-existing Condition Exclusion is:
Rate Category 1	365 days (90 days for high blood pressure and 180 days for cancer)	Exclusions 1, 2, 3 on page 5
Rate Category 2	365 days (90 days for high blood pressure and 180 days for cancer)	Exclusions 1, 2, 3 on page 5
Rate Category 3	180 days (90 days for high blood pressure)	Exclusions 1, 2, 3 on page 5
Rate Category 4	180 days (90 days for high blood pressure)	Exclusions 1, 2, 3 on page 5
Rate Category 5	90 days	Exclusions 1, 2, 3 on page 5
Rate Category 6	90 days	Exclusions 1, 2, 3 on page 5
For plans NOT requiring a Medical Declaration		
If you purchase:	Your Pre-existing Period is:	Your Pre-existing Condition Exclusion is:
Non-Underwritten Plan (age 60 to 75)	90 days	Exclusions 1, 2, 3 on page 5
Non-Underwritten Plan (age 76 or over)	2 years	Exclusion 4 on page 5
Canada Plan	Not applicable	Not applicable
40-Day PSHCP Supplemental	90 days	Exclusions 1, 2, 3 on page 5
If applicants are age 59 or under	180 days (90 days for high blood pressure)	Exclusion 1 on page 5
	365 days	Exclusions 5 a), b) and d) on page 5
	Ever	Exclusion 5 c) on page 5
Non-Medical Travel Plan	90 days	Exclusion 1, 2, 3 on page 5

PRE-EXISTING CONDITION EXCLUSIONS

This insurance does not cover losses or expenses caused directly or indirectly, in whole or in part, by:

1. Any medical condition⁴ (other than a minor ailment³) that was not stable² at any time during the applicable Pre-existing Period required by your plan, prior to each departure date*.
2. Your heart condition, if any heart condition was not stable² at any time during the applicable Pre-existing Period required by your plan, prior to each departure date*.
3. Your lung condition if:
 - a) any lung condition was not stable²; or
 - b) you have been treated¹ with oxygen or taken oral steroids (e.g., prednisone) for any lung condition, at any time during the applicable Pre-existing Period required by your plan, prior to each departure date*.
4. Any medical condition⁴ (other than a minor ailment³) for which you were treated¹/received treatment¹ at any time during the applicable Pre-existing Period, prior to each departure date.
5.
 - a) **any** lung condition for which you required hospitalization, the use of oxygen or treatment¹ with oral steroids (e.g. prednisone) at any time during the 365 days, prior to each departure date;
 - b) **any** heart condition which was not stable² at any time during the **365 days** prior to each departure date;
 - c) heart failure if you have **ever** been diagnosed or treated¹ for heart failure; or
 - d) **any** of the following conditions if you have been diagnosed or treated¹ for **a total of three or more** of these conditions at any time during the **365 days** prior to each departure date: any heart condition, any lung condition, high blood pressure or diabetes treated¹ with oral medication and/or insulin.

*purchase date (not departure date) in the case of the Non-Medical Travel Plan.

STEP 2 — GENERAL INFORMATION							
APPLICANT 1			APPLICANT 2				
Last Name		First Name		Last Name		First Name	
Date of Birth (dd/mm/yy)		<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth (dd/mm/yy)		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Street Address			City		Province		Postal Code
E-mail Address:			Telephone Number:				

If you are age 59 or under applying for family coverage, please call to apply.

STEP 3 — TRAVEL INFORMATION (Select a travel plan)						
	APPLICANT 1		APPLICANT 2			
1. Multi-Trip Annual Plan	<input type="checkbox"/> 9 days	<input type="checkbox"/> 16 days	<input type="checkbox"/> 22 days	<input type="checkbox"/> 9 days	<input type="checkbox"/> 16 days	<input type="checkbox"/> 22 days
	<input type="checkbox"/> 30 days	<input type="checkbox"/> 60 days	<input type="checkbox"/> 40 days PSHCP Supplemental	<input type="checkbox"/> 30 days	<input type="checkbox"/> 60 days	<input type="checkbox"/> 40 days PSHCP Supplemental
		Effective Date*: (dd/mm/yy)		Effective Date*: (dd/mm/yy)		
2. Single Trip Plan	Departure Date: (dd/mm/yy)		Departure Date: (dd/mm/yy)			
	Effective Date*: (dd/mm/yy)		Effective Date*: (dd/mm/yy)			
	Expiry Date: (dd/mm/yy)		Expiry Date: (dd/mm/yy)			
<input type="checkbox"/> Single Trip Daily Plan						
<input type="checkbox"/> Canada Plan						
<input type="checkbox"/> Non-Underwritten Plan						
<input type="checkbox"/> Non-Medical Travel Plan						

Effective Date: Coverage will begin at 12:01 a.m. on the effective date you choose.

*If you are adding this insurance as a top up to an existing coverage, the Effective Date will be the day after your existing coverage terminates.

Name of the Insurer for your existing coverage: _____ Number of Days: _____

Departure Date: This is the day you cross the border of your province, territory or residence or Canada.

Expiry Date: Coverage will terminate at 11:59 p.m. on the expiry date you choose.

STEP 4 — DEDUCTIBLES (CDN funds) Premium can be adjusted by selecting a deductible other than the automatic \$200 deductible below. Only available to applicants age 60 or over.												
	APPLICANT 1					APPLICANT 2						
Selection:	<input type="checkbox"/> \$0	<input type="checkbox"/> \$200	<input type="checkbox"/> \$500	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$0	<input type="checkbox"/> \$200	<input type="checkbox"/> \$500	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000
Premium Adjustment:	+10%	0%	-2.5%	-5%	-25%	-30%	+10%	0%	-2.5%	-5%	-25%	-30%

STEP 5 – PREMIUM CALCULATION AND METHOD OF PAYMENT (Refer to the Rate Sheet)		Applicant 1	Applicant 2
1.	Multi-Trip Annual Plan Premium	\$	\$
2.	Single Trip Plan Premium (for the Non-Medical Travel Plan, refer to line 12) a) Total Trip duration b) Existing coverage, if applicable c) Travel days covered by Single Trip Plan d) Single Trip Plan rate base on total trip duration in line a) e) Subtotal c) x d)	a) _____ days b) less _____ days c) = _____ days d) \$ _____ e) \$ _____	a) _____ days b) less _____ days c) = _____ days d) \$ _____ e) \$ _____
3.	Subtotal Daily + Annual Premium: 1 + 2 e)	\$	\$
4.	If you have smoked cigarettes during the 5 years prior to your departure date, calculate 10% of line 3 (not applicable to age 59 or under, to the Canada Plan or to the Non-Underwritten Plan)	\$	\$
5.	Deductible Options: add or subtract % shown in Step 4 (age 60 or over)	\$	\$
6.	Subtotal of lines 3, 4 and 5	\$	\$
7.	Vertis Discount: 5% of line 6 for each applicant (if applicable)	\$	\$
8.	Travel Companion Discount: 5% of line 6 for each applicant (if applicable)	\$	\$
9.	Green Discount: 1% of line 6 for each applicant (if applicable)	\$	\$
10.	Subtotal: add lines 7, 8, and 9 and subtract from line 6	\$	\$
11.	If you are topping up another carrier's coverage, add a \$15 top up surcharge.	\$	\$
12.	Non-Medical Travel Premium (if applicable) a) Value of trip (rounded to next \$100) b) Value of trip divided by 100 c) Premium = b) x rate found on Rate Guide d) Provincial Sales Tax (Saskatchewan 6%, Ontario 8%, Quebec 9%) of c) e) Subtotal c) + d)	a) \$ _____ b) \$ _____ c) \$ _____ d) \$ _____ e) \$ _____	a) \$ _____ b) \$ _____ c) \$ _____ d) \$ _____ e) \$ _____
13.	TOTAL PREMIUM (10 + 11+12e) The minimum premium is \$15 per policy.	\$	\$
14.	Admin Fee: Add \$15 per applicant. <i>No fee if you purchase online!</i>	\$	\$
Total Payment Submitted for both Applicant 1 and Applicant 2		\$	
Method of Payment: <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> Cheque (payable to: CanAm Insurance)			
Card Number		Expiry (dd/mm/yy)	Date (dd/mm/yy)
		Signature of Cardholder	

MEDICAL DECLARATION AGREEMENT

You must read and understand the importance of each of the following statements and sign below.

- **A PRE-EXISTING CONDITION EXCLUSION** may apply to medical conditions⁴ and/or symptoms that existed prior to my trip. I understand that any medical condition⁴ I have, including those disclosed in this Medical Declaration, if applicable, will be subject to the pre-existing condition exclusion(s) of the plan I qualify for. I will refer to my policy and to the above section for the full pre-existing condition exclusion clause.
- I personally provided the answers on this Medical Declaration, if applicable, and all information disclosed is true and accurate. The Insurer will, in the event of any sickness or injury, review my prior medical history and review my answers. I fully understand that if any of my answers are inaccurate, in the event of a claim, the Insurer will void my policy and my claim will be refused. I understand that the answers on my Medical Declaration are relevant to the risk and constitute the basis of my insurance. Where I was unsure of my medical history as it relates to the medical questions, I have verified it with my physician.
- I understand the necessity of calling ACM and obtaining prior approval before seeking medical attention in case of a claim or medical emergency. The toll free telephone number can be found on my wallet card and in my insurance policy.
- Medical Authorization in Case of a Claim – I understand that Manulife and ACM may investigate my claim. By signing this Medical Declaration, I also hereby direct and authorize any physician, health care practitioner, hospital or other medical care facility, pharmacy, the Ministry of Health or any other person who has attended and examined me or who has knowledge or records of me or my health, to furnish to Manulife and to ACM any or all information with respect to my sickness, injury, medical history, consultations, medicines or treatment and copies of all hospital or medical records for the purpose of investigating my claim. I hereby consent to the use by the insurer, its agents and administrators, as well as by Vertis Insurance Solutions Ltd. ("Vertis"), and by CanAm Insurance ("CanAm") of the personal and health information about me disclosed herein and in all documents or information provided in connection with my policy/policies of insurance for the purposes cited above. Any of the parties stated above may disclose to each other my personal and health information for the purposes cited above.

APPLICANT 1	Print (First, Last)	Signature	Date (dd/mm/yy)
APPLICANT 2	Print (First, Last)	Signature	Date (dd/mm/yy)

Your personal information is collected for the purpose of providing you with insurance services, claims analysis and payments. The information relating to the administration of benefits under this plan may be provided to third parties, to whom access has been granted, including Vertis Insurance Solutions Ltd. or those authorized by law. We will create a file with the information requested on this form to process your enrollment and to offer and administer insurance services. Your consent to the use of personal information, obtained in connection with this file, to offer you additional services or products is optional. Please call 1-866-943-5997 if you do not wish us to use your information for this purpose or to obtain a copy of our Privacy Policy.