Travel Guard®

Medical Questionnaire

Client Name: **Policy Number:**

Only the applicant can complete this Medical Questionnaire. Please read and answer carefully each question as any incorrect response may affect your coverage.
If you are unsure how to answer any of the following questions please consult with your Physician before completing this Medical Questionnaire. You must complete the Medical Questionnaire at the time of applying for your insurance coverage.

If your health status changes prior to your departure date (for annual plans this refers to any of your trip(s)), you must notify the insurer's authorized administrator at 1.866.878.0191 before you leave on your trip to find out how it will affect your coverage.

Eligibility To find out if you are eligible to purchase the insurance Policy, please answer "YES" or "NO" to the following questions.	YES	NO
1) In the last 12 months has a licensed Physician advised or recommended that you not travel?		
2) Has a licensed Physician ever diagnosed you with a terminal illness?		
3) Have you ever undergone a bone marrow transplant or an organ transplant (excluding corneal transplant) that requires the use of anti-rejection (immune suppression) drugs?		
4) Do you require dialysis of any type for a kidney disease?		
5) In the last 12 months have you been prescribed or utilized home oxygen therapy at any time?		
6) In the last six (6) months, have you been Hospitalized for any stroke/cerebrovascular, respiratory condition, liver disorder, kidney disorder or cardiovascular disorder?		
7) Have you ever received a diagnosis and/or had treatment and/or been hospitalized and/or been prescribed or taken medication for four (4) of the following conditions: cardiovascular, cerebrovascular, respiratory, kidney disorder, diabetes, high blood pressure or liver disorder?		

If you answered "YES" to any question above then you are ineligible to purchase the insurance Policy you are applying for. Do not continue to complete this Medical Questionnaire.
If you answered "NO" to all the questions above please proceed and complete the entire Medical Questionnaire to determine your rate and the applicable medical exclusion.
Each question assigns a point value for each "YES" answer you provide.

Rate Qualification	YES	NO	SCORE
8) Have you used tobacco products of any nature in the last two (2) years?			10
9) Has it been more than 18 months since your last regular check-up with your family Physician?			10
10) In the last six (6) months have you been prescribed a new medication by a licensed Physician (not including medication for a Minor Ailment)?			20
11) In the last six (6) months have you been advised by a licensed Physician to have a test, investigation or surgery that you haven't had yet?			100
12) Have you ever tested positive for the Human Immunodeficiency Virus (HIV)?			100
13) In the last two (2) years have you been investigated for, received treatment for, been diagnosed with a stroke or mini stoke (TIA)?			50
14) In the last 12 months have you been diagnosed with high blood pressure and not prescribed any treatment or medication but a licensed Physician has suggested life style change?			10
15) In the last 12 months have you been diagnosed with or treated for high blood pressure and prescribed two (2) or more medications?			30
16) In the last 12 months have you been diagnosed with or treated for high blood pressure and prescribed only one (1) medication?			20
17) In the last 12 months have you received insulin for diabetes?			50
18) In the last 12 months have you been investigated for diabetes and/or are you managing your condition by diet or oral medication?			30
19) In the last 12 months have you been investigated for, received treatment for or been diagnosed with Peripheral Vascular Disease or Aneurysms?			30
20) In the last 12 months has a licensed Physician diagnosed you with cancer which has metastasized?			90
21) In the last six (6) months have you been treated for cancer of any sort?			30
22) In the last 12 months has a licensed Physician investigated or diagnosed you with, have you taken medication for, or have you been treated for any type of liver disorder?			40
23) In the last 12 months have you been investigated for, received treatment for or been diagnosed with Kidney or Renal Failure/ Insufficiency?			30
Heart Conditions			
24) Have you had heart bypass surgery or angioplasty more than nine (9) years ago?			100
25) In the last 12 months have you been Hospitalized for any heart condition?			100
26) Have you ever been investigated for, received treatment for or been diagnosed for any heart condition including valve disease?			70
27) In the last six (6) months have you experienced a worsening of an existing heart condition or experienced new symptoms of an existing heart condition?			100
28) In the last six (6) months has a licensed Physician prescribed nitro for your heart condition?			90
29) In the last six (6) months have you had a change in medication for a heart condition?			70
30) In the last 12 months have you ever been investigated for, received treatment for or been diagnosed with shortness of breath or chest pain?			50
31) Have you been prescribed or are you currently taking diuretics of any sort for a heart condition?			50
Lung Conditions			
32) Have you ever been investigated for, been diagnosed with, or received treatment (more than 10 consecutive days) for a lung condition?			40
33) In the last 12 months have you been Hospitalized for a lung condition or respiratory condition or experienced a worsening of an existing lung condition?			100
34) In the last 12 months have you been prescribed seven (7) or more consecutive days' use of any steroid medication (including inhalers) including, but not limited to, prednisone or prednisolone for a lung condition?			100
35) In the last 12 months have you been prescribed three (3) or more medications (including inhalers) for lung condition(s)? (Please be sure to check your puffer if you have one as it may include more than one (1) inhaled medication)			70
36) In the last six (6) months have you had a change in medication for a lung condition?			70

For every "YES" answer please add up all the points to get your FINAL TOTAL

TOTAL POINTS: ____

Based on your Total Points initial the rate that applies to you in the chart below.

Read the Declaration and Authorization carefully then complete the questionnaire by placing your name, signature and date at the bottom.

Total Points	Applicable Medical Exclusion	Rate Chart *(circle one)*	My Initials
0	General Exclusion Only (GE)	1	
10 to 20 points	General Exclusion and Medical Exclusion 1 (ME #1)	2	
30 to 40 points	General Exclusion and Medical Exclusion 2 (ME #2)	3	
50 to 90 points	General Exclusion and Medical Exclusion 2 (ME #2)	4	
100 points or greater	General Exclusion and Medical Exclusion 3 (ME #3)	5	

Declaration and Authorization:

I certify that all statements and information provided by me in connection with this Medical Questionnaire are true and complete. I understand this Medical Questionnaire forms part of my application for an insurance Policy from AIG Insurance Company of Canada (the "Insurer").

I understand that my eligibility and health information are material and that any non-disclosure or misrepresentation in this Medical Questionnaire will void my insurance Policy; I will not be covered for any benefits, my premium will be refunded and any monies paid out on my behalf will be collected from me.

I further understand that if I have a change in my health (including medication changes) prior to my departure date I must notify the administrator before I leave on my trip. I understand that coverage is not effective until approval of my application and until full premium has been paid.

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 conditions to release to the Insurer, and its affiliates, third party administrators, agents, legal representatives and reinsurers any such information for the purpose of this Medical Questionnaire, the insurance Policy and any subsequent claim.

A copy or facsimile of this authorization shall be deemed as valid as the original.

PLEASE REVIEW YOUR ANSWERS CAREFULLY BEFORE SIGNING.

Signature

Name of the Applicant Date Signed

Insurance by AIG Insurance Company of Canada
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