

Canada

Immigrant Insurance Cover



Howick & Hill
INSURANCE GROUP

Underwritten by CUMIS General Insurance Company, a member of The Co-operators group of companies. Howick & Hill Insurance Group retains full discretion to appoint an underwriter for any specialized, high-risk, or non-standard or exceptional policy requirements.

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 at: 1-647-493-6441
- 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.

Mail, fax or email it back to us
HcH Group Service Canada Inc.
o/a Howick & Hill Insurance Group

Underwriting Department 250 Yonge Street, Suite 2100 Toronto, Ontario M5B 2L7 Canada

Fax: 1-866-256-237 or 1-647-493-6441

Email: directassistance.ca

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

Eligibility

1. Coverage is NOT AVAILABLE to any individual who, as of the effective date:

- has been diagnosed with a terminal illness; or
- has been diagnosed with stage 3 or 4 cancer; or
- has received treatment for any cancer (other than basal or squamous cell skin or breast cancer treated only with hormone therapy) in the past 3 months; or
- requires assistance with activities of daily living as the result of a medical condition or state of health.

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

MM/DD/YYYY male
 female

Last name (please print) _____ First name _____ Date of birth _____

Previous HcH Group 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

Agent's name _____ Agent's code _____

Send correspondence by

Fax E-mail 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

	MM/DD/YYYY Departure date	MM/DD/YYYY Return date
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- \$10,000
 \$25,000
 \$50,000
 \$100,000
 \$150,000
 \$300,000

Your medical Information

1. Have you smoked or used any tobacco products in the last 5 years?
 NO YES
 Height _____ ft/ in cm

2. When was the last visit to your physician or medical clinic?
 (mm/dd/yyyy)
 Weight _____ lbs kg

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

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

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 <input type="checkbox"/> NO <input type="checkbox"/> YES - please check all that apply Lou Gehrig's disease	scleroderma acquired immune deficiency (AIDS) or human immunodeficiency virus (HIV) multiple sclerosis	systematic lupus erythematosis sarcoidosis any location myasthenia gravis other _____
Blood disorder <input type="checkbox"/> NO <input type="checkbox"/> 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 <input type="checkbox"/> NO <input type="checkbox"/> YES - please check all that apply high blood pressure not taking medication	taking medication <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3+ medications high cholesterol not taking medication taking medication <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 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: brain heart
 abdominal
 thoracic

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
nomedication
prednisone
inhaler
bronchitis
3 or more episodes in last 24 months

tuberculosis
pulmonary fibrosis
use of home oxygen
lung transplant
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
heart transplant

➔ 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

celiacdisease
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
liver transplant

Throat

scleroderma, dysphagia, incoordination or achalasia

Other _____

Kidney or urinary condition

NO YES-pleasecheckall that apply

kidney failure
kidney dialysis

kidney transplant
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)	MM/DD/YYYY Date
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Please tell us about the history of ALL your medical conditions you checked on page 2 and 3. 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 Howick Curl Hill Insurance Group Service Canada Inc. o/a HcH 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 HcH 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. HcH 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 regarding your health, medical history and treatment to HcH 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

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

NO YES

Applicant's name (please print) _____
 MM/DD/YYYY _____
 Date _____

Signature _____
 MM/DD/YYYY _____
 Signature date _____

