APPLICATION

Travel Edge & Travel Edge Plus Insurance

ADVICE. INSURANCE. INVESTMENTS.

For assistance in filling out this application call: **CDSPI Advisory Services Inc.**
1.800.561.9401 or 416. 296.9401, E-mail: insurance@cdspiadvice.com

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Please complete all pertinent questions to avoid processing delays and return to:
CDSPI, 155 Lesmill Road, Toronto, ON M3B 2T8 Fax: 1.866.337.3389 or 416.296.8920

INDIVIDUAL INFORMATION

Section 1 Applicant Information

1. Name (*please print*):
☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Last First Middle or Middle Initial

2. Mailing Address *(check one)*: ☐ Home ☐ Business

Street and Number Suite No.

City/Town Province Postal Code

3.
Business Telephone Home Telephone

Mobile Telephone Fax

4.
E-mail address

5. Account Number, if known: ⌊ | | | | | ⌋

6. Language Preference: ☐ English ☐ French

Section 2 Party To Be Insured

To be eligible for coverage you must:
a) be at least 15 days old and up to age 75 inclusively; and
b) be insured for benefits under a Canadian government health insurance plan during the entire *period of coverage*.

Note: Please complete all questions even if the Applicant is the party to be insured.

1. Name (*please print*):
☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Last First Middle or Middle Initial

2. Birth date: ⌊ | | | | | | | | ⌋
Day Month Year

3. STATUS (*complete item A, B, C or D*):

A. ☐ Dentist
☐ Member of Provincial/Territorial Dental Association*
☐ Member of CDA
* Excluding the ACDQ in Quebec.

Year of Graduation: ⌊ | | | | | | | | ⌋
Day Month Year

Name of University or Dental Faculty: _____

Dental Specialty: _____

☐ Student
Name of University or Dental Faculty: _____

☐ Retired Dentist

☐ Dentist receiving disability benefit

B. ☐ Eligible Family Member of eligible dentist

Name of Dentist: _____

Specify Relationship to Dentist _____

C. ☐ Hygienist
☐ Certified Dental Assistant
☐ Other Employee
In all cases please specify
Name of Dentist Employer: _____

☐ Eligible Family Member of Hygienist, Dental Assistant or Employee

Name of Hygienist, Dental Assistant or Employee:

_____

Specify Relationship: _____

Name of Dentist Employer: _____

D. ☐ Association Staff

Name of Association: _____

☐ Retired Employee of Association

☐ Eligible Family Member of Association Staff

Name of Association: _____

Name of Association Staff Member: _____

Specify Relationship: _____

Section 3 Other Parties To Be Insured

Complete only if applying for Family coverage.

To be eligible for coverage each person listed below must:
a) be at least 15 days old and up to age 75 inclusively; and
b) be insured for benefits under a Canadian government health insurance plan during the entire period of coverage.

1. List below all family members (spouse or common-law partner and/or dependent children under 21, and up to age 25 if attending college or university full-time) from oldest to youngest and if applicable, your children's caregiver*. If you are selecting Top-up coverage as well, please check boxes in the last column to indicate parties travelling on the trip using that coverage, and be sure to complete section 8.

Note: If the applicant is also travelling under Top-up coverage, check here: ☐

Name (first/last)	Relationship (spouse, common-law partner, child or caregiver)	Date of Birth (day/month/year)	Full-time Student?	Mental or Physical Infirmity?	Insured under a Government Health Insurance Plan?	Travelling Under Top-up Coverage?
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If more space is required for additional persons, please attach the information on a separate piece of paper.

** A caregiver can also be insured. A caregiver is a person (18 years of age or older, not related to you by blood or marriage) who is employed on a full-time basis to provide childcare in your family home. Coverage for the caregiver applies when she/he is traveling with your dependent children.*

Note: Travel cards are issued to those insured under the plan who are age 16 and over. If travel cards are required for younger children, please advise us at the time of application.

COVERAGE APPLIED FOR

Section 4 Details

1. A. Type of Coverage

☐ Travel Edge (Medical Coverage)
☐ Travel Edge *Plus* (Medical, Flight Accident, Baggage Loss and Trip Cancellation Coverage)

B. Maximum trip length:
☐ 15 days ☐ 30 days ☐ 60 days ☐ 90 days

C. ☐ Single coverage ☐ Family coverage

2. Coverage for Travel Insurance is in effect for one year, and begins on the date your application and premium payment are received by CDSPI. However, you may specify a later effective start date for coverage:

|__|__|__|__|__|__|__|__|
Day Month Year

3. We will process your travel application, travel cards, and payment upon receipt unless you indicate to hold processing until 3 weeks prior to the effective date by checking the box below:

☐ Hold processing

Section 5 Beneficiaries – Complete ONLY if Applying for Travel Edge *Plus* Coverage

1. Below, list primary beneficiaries and contingent beneficiaries for the **Travel Edge *Plus*** Coverage for the person to be insured. In addition, if you are applying for Travel Edge *Plus* Family Coverage, list primary beneficiaries and contingent beneficiaries for your spouse.

If a beneficiary is designated as revocable, you will be able to change the beneficiary and coverage at any time without the beneficiary's consent. If the beneficiary is irrevocable, the beneficiary's written consent will be required in order to change the beneficiary, reduce coverage, cancel the policy, or make any other changes that may affect the value or ownership of the policy.

Except for a spouse beneficiary in Quebec (see below), a beneficiary designation will be revocable unless you make it irrevocable (for reasons such as satisfying the requirements of a divorce judgment, separation agreement, court order or partnership insurance agreement) by checking the box in the "irrevocable" column below.

In Quebec, the designation of a spouse as beneficiary is deemed irrevocable, unless you specify that the designation is revocable by checking the box in the Quebec column below.

If you name a minor as a beneficiary, please provide the name of the trustee appointed to receive any payment due to the minor beneficiary, following the person to be insured's death.

If you name more than one primary beneficiary, please record the percentage of the death benefit each beneficiary is to receive. If no percentage is recorded, the death benefit will be divided evenly among the surviving eligible primary beneficiaries. You may also name one or more contingent beneficiaries who will receive a death benefit only if: (a) no primary beneficiaries are alive when the benefit is payable; or (b) a court decides that the primary beneficiaries are not eligible.

Note: If sufficient space is not available, check here ☐ and complete a separate signed and dated sheet and attach to this form. Please follow the format used below, including percentage distribution if naming multiple beneficiaries.

A. Person to be insured (complete in all cases):

	Name in Full (Last, First, Middle or Middle Initial)	Relationship to Person To Be Insured	Proportion (%)	Check only if making irrevocable (see above)	In Quebec, check to make spouse beneficiary revocable
Primary Beneficiary				☐	☐
Primary Beneficiary				☐	☐
Primary Beneficiary					
Primary Beneficiary					
			Total 100%		
Contingent Beneficiary				N/A	☐
Contingent Beneficiary				N/A	☐

B. Spouse (complete only if family coverage is selected):

	Name in Full (Last, First, Middle or Middle Initial)	Relationship to Person To Be Insured	Proportion (%)	Check only if making irrevocable (see above)	In Quebec, check to make spouse beneficiary revocable
Primary Beneficiary				☐	☐
Primary Beneficiary				☐	☐
Primary Beneficiary					
Primary Beneficiary					
			Total 100%		
Contingent Beneficiary				N/A	☐
Contingent Beneficiary				N/A	☐

2. If you named a minor as a beneficiary above, please provide the name of the trustee appointed to receive any payment due to the minor beneficiary, in the event of the death of the person to be insured.

A. Beneficiary Name: _____

B. Trustee Name: _____

C. Relationship of Trustee to Person To Be Insured: _____

Note: If any children are covered under the plan, the applicant is automatically designated as the beneficiary under the child's coverage.

CALCULATION OF ANNUAL PAYMENT

Section 6 Single Coverage

1. A. Enter your premium using the Travel Edge or Travel Edge Plus tables below: $ ____

B. Enter applicable provincial tax using the tables below: + $ ____
Travel Edge Plus – SK, MB, ON, QC & NFLD only

C. Total the premium and tax and enclose payment of: = $ ____

Section 7 Family Coverage

	First Insured	Second Insured
1. A. Using the ages of the two oldest family members, enter each individual's premium using the Travel Edge or Travel Edge *Plus* tables below:	$ ____	$ ____
B. Enter applicable provincial tax using the tables below: **Travel Edge Plus – SK, MB, ON, QC & NFLD only**	+ $ ____	$ ____
C. Total the individual premium and taxes:	= $ ____	+ $ ____
D. Add the two individual amounts and enclose payment of:		= $ ____

TRAVEL EDGE				
Age	**15 Days**	**30 Days**	**60 Days**	**90 Days**
50 or under	$ 54.03	$ 64.84	$185.71	$304.57
51 – 65	$ 88.56	$106.28	$211.49	$381.94
66 – 75	$187.62	$225.14	$428.11	$746.68

TRAVEL EDGE *PLUS*				
Age	**15 Days**	**30 Days**	**60 Days**	**90 Days**
50 or under	$237.81	$285.36	$396.86	$ 515.23
51 – 65	$270.56	$324.69	$421.77	$ 587.45
66 – 75	$430.26	$516.31	$707.60	$1,009.20

TRAVEL EDGE *PLUS* APPLICABLE TAX – APPLIES TO SK, MB, ON, QC AND NL				
Saskatchewan	**15 Days**	**30 Days**	**60 Days**	**90 Days**
50 or under	$14.27	$17.12	$23.81	$30.91
51 – 65	$16.23	$19.48	$25.30	$35.25
66 – 75	$25.82	$30.98	$42.46	$60.55
Manitoba and Ontario	**15 Days**	**30 Days**	**60 Days**	**90 Days**
50 or under	$19.03	$22.83	$31.75	$41.22
51 – 65	$21.65	$25.97	$33.75	$47.00
66 – 75	$34.42	$41.31	$56.60	$80.74
Quebec	**15 Days**	**30 Days**	**60 Days**	**90 Days**
50 or under	$21.40	$25.68	$35.72	$46.37
51 – 65	$24.35	$29.22	$37.96	$52.88
66 – 75	$38.72	$46.47	$63.68	$90.83
Newfoundland and Labrador	**15 Days**	**30 Days**	**60 Days**	**90 Days**
50 or under	$35.67	$42.81	$ 59.53	$ 77.28
51 – 65	$40.59	$48.71	$ 63.27	$ 88.12
66 – 75	$64.53	$77.45	$106.14	$151.38

Section 8 Additional Coverage Options

1. Top-up Travel Coverage:

Your travel coverage is provided for a limited number of days per trip. Top-up allows you to extend your emergency medical travel protection for a particular trip. Complete this section if you need to top-up your coverage.

A. Departure Date: Day Month Year

B. Return Date: Day Month Year

C. Number of Top-up Days Required*:

D. Top-Up Daily Rate (from table below): x $

Note: For family coverage, add the daily rates for the ages of the two oldest people travelling.

E. Total payment (C x D): = $

** The number of Top-up Days equals the number of days of your trip beyond 15, 30, 60 or 90 days, whichever is in effect under your annual plan.*

TOP-UP DAILY RATES			
Total Travel Period Days	**Age**		
	0-50	**51-65**	**66-75**
1-59	$2.39	$2.86	$ 5.16
60-89	$2.98	$3.21	$ 7.16
90-119	$4.66	$4.68	$10.29
120-149	$5.08	$5.21	$11.91
150-183	$5.49	$6.27	$12.22

2. Additional Trip Cancellation Coverage:

Trip Cancellation coverage (available only for Travel Edge *Plus*) offers a basic coverage amount of $2,000 per insured. Additional Trip Cancellation coverage can be purchased on a per-trip basis to the value of the transportation ticket to a maximum of $15,000 for a person with single coverage or $30,000 for two or more family members with family coverage (regardless of the number of people in the family). Fill out this section only if you require such additional coverage. Note: Additional coverage is available in units of $100 only.

A. This **additional** coverage is for (check all that apply):

Rate per $100	
Ages 65 and under	$5.40
Over age 65	$8.79

Additional amount requested (multiple of $100 only):

☐ Applicant $
Amount requested divided by 100:
x Rate per $100: $ (a)

☐ Spouse $
Amount requested divided by 100:
x Rate per $100: $ (b)

☐ Child(ren)

Child's Name: $
Amount requested divided by 100:
x Rate per $100: $ (c)

Child's Name: $
Amount requested divided by 100:
x Rate per $100: $ (d)

Child's Name: $
Amount requested divided by 100:
x Rate per $100: $ (e)

☐ Caregiver $

Caregiver's Name: $
Amount requested divided by 100:
x Rate per $100: $ (f)

B. Pretax amount: (a+b+c+d+e+f): $

C. Add applicable provincial tax (only applies to Saskatchewan (6%), Manitoba (8%),Ontario (8%), Quebec (9%) and Newfoundland and Labrador (15%) residents): $

D. Total amount for additional Trip Cancellation coverage (B + C): $

E. Departure Date: Day Month Year

F. Return Date: Day Month Year

DECLARATION OF INSURABILITY

Section 9 Single or Family Coverage

To be completed by all parties to be insured.

HEALTH INFORMATION

1. Using the chart below, please provide a "Yes" or "No" answer (for each person to be insured) to the following questions. If any of the following medical questions are answered "Yes", the individual(s) for whom a "Yes" answer was given is/are not eligible for this coverage.

Note: Coverage is not applicable for any *pre-existing medical condition* if that condition was not *stable* in the 90 days immediately before each *departure date*.

Have you:

A. Been diagnosed with a terminal illness?

B. Been diagnosed with or had an episode of congestive heart failure?

C. Been diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)?

D. Been diagnosed with Alzheimer's disease or any other type of dementia?

E. Received any type of treatment for pancreatic cancer, liver cancer or any other type of cancer that has metastasized?

F. Been prescribed or used home oxygen treatment in the past 12 months?

G. Had a major organ transplant (i.e. heart, kidney, liver and/or lung)?

H. Received kidney dialysis treatment in the past 12 months?

	A	B	C	D	E	F	G	H
Person to be Insured:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Spouse or partner:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Caregiver (If applicable):	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Children (Name):	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

DECLARATION AND AUTHORIZATION

Section 10 To Be Read, Signed and Dated By The Person To Be Insured/Secondary Insured*

I hereby apply to CUMIS, a member of The Co-operators group of companies for Travel Insurance offered by CDSPI. I acknowledge receipt of and confirm my agreement with the Notice on Privacy and Confidentiality set out below.

I/We declare that the information provided is complete and true to the best of my/our knowledge. I/We understand that the questionnaire and application forms part of the travel insurance agreement provided by CUMIS and administered by CDSPI. I/We further understand that any misrepresentation or non-disclosure concerning any medical condition identified in this Health Questionnaire that leads to a claim may result in non-payment of that claim. Any medical condition which I/we may now have but have not fully disclosed in Section 9 or which develops prior to my/our departure date will be subject to the pre-existing condition exclusion contained in the policy.

I reserve the right to revoke or alter the interest of any beneficiary named in this application, subject to any applicable law.

I/We hereby authorize any licensed physician, medical practitioner, hospital clinic or other medical or medically related facility, insurance company, Government Health Insurance Plan or other organization or person that has any records or knowledge of my/our health and/or that of my/our family members, to give to the Companies any information regarding my/our health, medical history and treatment. A reproduction of this Authorization shall be as valid as the original.

_____ Date: |_|_|_|_|_|_|_|_|
Signature of Person To Be Insured Day Month Year

_____ Date: |_|_|_|_|_|_|_|_|
Signature of Secondary Insured* (for Family coverage) Day Month Year

** The oldest family member other than the applicant.*

Travel Edge Insurance and Travel Edge Plus are underwritten by CUMIS General Insurance Company, a member of The Co-operators group of companies, and administered by Allianz Global Assistance. Allianz Global Assistance is the registered business name of AZGA Service Canada Inc. and AZGA Insurance Agency Canada Ltd.

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Section 11 Method of Payment

1. Method of Payment (*check one*):
- ☐ Cheque (payable to CDSPI)
- ☐ VISA
- ☐ MasterCard

Card No.: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Expiry Date: |_|_|_|_| Month Year

I, the undersigned, authorize CDSPI to debit the specified credit card account for the premiums for this travel insurance:

Name of Cardholder: _____

Signature: _____

Date signed: |_|_|_|_|_|_|_|_| Day Month Year

NOTICE ON PRIVACY AND CONFIDENTIALITY – **Must be detached, read and retained by the person to be insured**

The information requested on the application form is required to process the application. To protect its confidentiality, access to this information will be restricted to those employees, mandataries, administrators or agents of any of AZGA Service Canada Inc. o/a Allianz Global Assistance and/or member companies of The Co-operators, CDSPI and/or CDSPI Advisory Services Inc. who are responsible for underwriting, marketing and administration of services and the processing, facilitating and investigation of claims, and to any other person you authorize or as authorized by law. You may request to review and make corrections to the personal information contained in your file at:

- Allianz Global Assistance by writing to: Privacy Officer, AZGA Service Canada Inc. o/a Allianz Global Assistance, 250 Yonge Street, Suite 2100, Toronto, ON M5B 2L7
- CDSPI or CDSPI Advisory Services Inc. by writing to: The Chief Privacy Officer, 155 Lesmill Rd., Toronto, ON M3B 2T8