Visitors to Canada MEDICAL DECLARATION - Version V10

Instructions: a) Complete for any applicant who will be age 55 to 85 on the Effective Date who is applying for the Enhanced Plan.
b) Agent must fax to 1-866-285-5727 or email to info@21stcenturytravelins.com within 3 business days of making sale.

Agency Name _____ Agent Code _____

Policy Number *(if already issued in TIPS system)* _____ Agent Ph#: _____

Name of Applicants *(Last name, first name)*	**Date of Birth** *(mm/dd/yy)*
Applicant 1:	
Applicant 2:	
Phone number(s) for contact purposes:	

ELIGIBILITY

You are not eligible for ANY coverage with 21st Century Travel Insurance if you:

- are travelling against the advice of a physician;
- have been diagnosed with a terminal illness with less than **2 years** to live;
- have been diagnosed with or received treatment within the past **2 years** for pancreatic, lung, brain or liver cancer;
- have ever been diagnosed with any type of cancer that has spread from one part or organ of the body to another (metastatic cancer);
- have had or are waiting for an organ or bone marrow transplant (excluding corneal transplant);
- have ever been diagnosed with Congestive Heart Failure;
- have been prescribed or used home oxygen in the last **12 months**;
- require kidney dialysis; and/or
- reside in a nursing home, or long term care facility?

Circle Yes or No

Answer the following questions to determine eligibility for the Enhanced Plan if you are age 55 to 85.	**Applicant 1**	**Applicant 2**
1. Within the past **12 months**, and in relation only to the medical conditions listed below, have you: - been newly diagnosed with; - been prescribed any new medication or any *change in medication* for; - had any new or change in treatment, including investigation or testing (do not count regular scheduled maintenance investigations or testing); - been referred to a specialist for; or - been hospitalized or seen in the emergency department of a hospital for: Any of the following medical conditions: a) a heart condition b) a lung condition c) shortness of breath d) chest pain e) stroke, or mini-stroke or TIA (Transient Ischemic Attack)? ***Change in medication*** means the medication dosage, frequency or type has been reduced, increased, stopped and/or new medication(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 condition; and, a change from a brand name medication to a generic brand medication of the same dosage.	Yes No	Yes No
2. Have you had a heart bypass, heart valve surgery or angioplasty more than **10 years** ago (use the date of the most recent procedure)?	Yes No	Yes No
3. Within the past **12 months** have you: a) been treated for and/or been diagnosed with internal bleeding; or b) been admitted to hospital for a gastrointestinal disease or disorder; or c) received treatment including investigation or testing where the results indicate either a new diagnosis of cancer or that cancer has returned or spread (except basal cell and squamous cell skin cancer or breast cancer treated only with hormonal therapy)?	Yes No	Yes No
4. Within the past **12 months** have you been prescribed or taken any of the following: a) prednisone for any lung condition; or b) any form of nitroglycerin for the relief of angina pain (including on an "as needed" basis)?	Yes No	Yes No
5. Within the past **12 months** have you been prescribed or taken medications for **both** diabetes **and** a heart condition? (Answer **No** if you are medicated for one but not both of these conditions. Medication prescribed solely for the control of blood pressure is not a medication for a heart condition.)	Yes No	Yes No

Age 55 to 85

If you answer "No" to all questions above, you are eligible to purchase the Enhanced Plan. Use Enhanced Plan Rates.
If you answer "Yes" to any question 1 through 5, you are eligible for either the Standard Plan or Basic Plan.

Declaration. I/we certify that the information provided on this form is true and accurate, and understand that such information is material to the risk, and constitutes the basis of coverage offered. I/we fully understand that if any of my/our answers are untrue or incorrect, then coverage offered will be null and void. I/we understand that the policy contains important terms and conditions of coverage including exclusions and other limitations. I/we understand that Manulife, its agents, third party administrators or its legal representatives may investigate a claim. I/we authorize any hospital, physician, or their medical service provider, or any other organization or person that has any records or knowledge of me/us and my/our health to release to third party administrators, and Manulife and its reinsurers, any such information for the purpose of this application, contract and subsequent claim.

If you are completing this declaration on behalf of the applicant(s) for insurance, please complete the following:

Your name _____ Relationship to applicant(s) _____

Your signature _____ Date _____

If you are the applicant(s) for insurance, please complete the following:

	Applicant Signature	**Name of Applicant** (Print)	**Date** *(mm/dd/yy)*
Applicant 1			
Applicant 2			