TRAVELSTAR® TRAVEL INSURANCE
Application

TC

You must be a Canadian resident in order to purchase TravelStar Travel insurance. Plans are not available in Quebec and New Brunswick.

A. Applicant Information *(Please list dependants travelling with you.)*

Applicants	First Name	Last Name	Sex	Date of Birth *(DD/MM/YYYY)*	Age
1			❑ M ❑ F		
2			❑ M ❑ F		
Dependant Applicants					
1			❑ M ❑ F		
2			❑ M ❑ F		
3			❑ M ❑ F		
4			❑ M ❑ F		

Address	City

Province	Postal Code	Phone ( )	Email

B. Plan Selection *(Plans must be purchased before departing on a trip.)*

Plan	Notes/Instructions
❑ Multi-Trip Annual Emergency Medical	*Only available to applicants under the age of 80 at the time of application.* *Complete page 2, section F1 on page 3, and page 4.*
❑ Multi-Trip Annual Trip Cancellation	*Only available with the purchase of a Multi-Trip Annual Emergency Medical Plan.* *Complete section C., section F2 on page 3 and page 4.*
❑ Single-Trip Emergency Medical	*Complete page 2, section F3 on page 3 and page 4.*
❑ Single-Trip Trip Cancellation	*Complete section C., section F4 on page 3 and page 4.* *If your trip is valued at $12,000 or more, you must also complete section D. on page 2.*

C. Eligibility for Trip Cancellation Coverage *(Complete this section if you are applying for Trip Cancellation Coverage.)*

You ("you" and "your" refers to any person listed on this application) are NOT eligible for coverage if:

1. you are not a Canadian resident;
2. you did not purchase the plan prior to your departure;
3. your trip is to a country with an "Avoid non-essential travel" or "Avoid all travel" advisory from the Canadian government in effect at:
   a) the time of purchase if purchasing a Single-Trip Plan; or
   b) the time of booking if purchasing a Multi-Trip Annual Plan;
4. your trip is valued at $12,000 or more and you do not meet the Single-Trip Emergency Medical Plan eligibility requirements, regardless of your age; and
5. your trip is valued at more than $20,000 if you are purchasing a Single-Trip Plan.

	Applicant 1	Applicant 2
I hereby warrant that I AM eligible to purchase Trip Cancellation Coverage	❑ Yes ❑ No	❑ Yes ❑ No
I hereby warrant that my dependants are eligible to be covered under my Trip Cancellation Coverage based on the above questions.	❑ Yes ❑ No	

D. Eligibility for Emergency Medical Coverage *(Complete this section if you are applying for Emergency Medical Coverage.)*

You ("you" refers to any person listed on this application) are NOT eligible for coverage if you:

1. are awaiting tests or medical treatment for a heart condition;
2. have a surgically untreated vascular aneurysm;
3. have been diagnosed with Congestive Heart Failure (CHF);
4. have an Implantable Cardioverter Defibrillator (ICD);
5. were diagnosed; received new medical treatment (e.g. consultation, tests or prescription drugs); or had a change in your medical treatment (e.g. a stop, start or dosage change to a prescription drug, other than a dosage change of Coumadin or Warfarin) for, any of the following heart or vascular conditions in the last twelve (12) months:
   a) heart transplant;
   b) atrial flutter;
   c) atrial/ventricular fibrillation;
   d) peripheral vascular disease;
   e) stroke/TIA; or
   f) blood clots;
6. have diabetes that is treated with insulin AND take prescription medication for a heart condition (excluding medication to treat high cholesterol or high blood pressure);
7. use home oxygen or take an oral steroid to treat a lung condition;
8. are currently being treated for cancer, excluding breast or prostate cancer treated exclusively with hormone therapy;
9. were diagnosed; received new medical treatment (e.g. consultation, tests or prescription drugs); or had a change in your medical treatment (e.g. a stop, start or dosage change to a prescription drug) for, any of the following conditions in the last twelve (12) months:
   a) liver failure;
   b) GI bleed;
   c) AIDS; or
   d) terminal illness;
10. have had any of the following procedures in the last twelve (12) months:
    a) valve surgery or replacement;
    b) kidney dialysis;
    c) organ, stem cell or bone marrow transplant;
11. require assistance from another person(s) with activities of daily living (ADL) if you are seventy (70) years of age or older;
12. are not a Canadian resident;
13. have not purchased prior to departing on your trip; and
14. are eighty (80) years of age or older at the time of application if purchasing a Multi-Trip Annual Emergency Medical Plan.

	Applicant 1	Applicant 2
I hereby warrant that I AM eligible to purchase Emergency Medical Coverage	❑ Yes ❑ No	❑ Yes ❑ No
I hereby warrant that my dependants are eligible to be covered under my Emergency Medical Coverage based on the above questions.	❑ Yes ❑ No	

E. Medical Questionnaire *(This section is ONLY for applicants age 60 and over purchasing Emergency Medical Coverage.)*

	Applicant 1	Applicant 2
	If answering "YES", please indicate the specific condition(s) on the left.	
1. Have you ever suffered from, been diagnosed with, received treatment for, or been prescribed drugs for any of the following medical conditions, or undergone any of the following medical procedures:		
a) ❑ Heart/Cardiovascular Disease or Condition, ❑ Heart Attack, ❑ Angina, ❑ Irregular Heartbeat, ❑ Heart Surgery, ❑ Coronary Angioplasty, ❑ Stenting, ❑ Bypass, ❑ Valve Replacement or Valve Surgery	❑ Yes ❑ No	❑ Yes ❑ No
b) ❑ Stroke/TIA, ❑ Blood Clots, ❑ Aneurysm, ❑ Peripheral Vascular Disease, ❑ Carotid Stenosis	❑ Yes ❑ No	❑ Yes ❑ No
c) Chronic Lung Disease (e.g. Chronic Obstructive Pulmonary Disease (COPD)/Emphysema/Persistent Asthma)	❑ Yes ❑ No	❑ Yes ❑ No
d) ❑ Bone Marrow or ❑ Organ Transplant	❑ Yes ❑ No	❑ Yes ❑ No
e) HIV	❑ Yes ❑ No	❑ Yes ❑ No
2. In the past two years have you suffered from, been diagnosed with, received treatment for or been prescribed drugs for any of the following medical conditions:		
a) Cancer (excluding Basal Cell Carcinoma)	❑ Yes ❑ No	❑ Yes ❑ No
b) Diabetes	❑ Yes ❑ No	❑ Yes ❑ No
c) Pancreatitis	❑ Yes ❑ No	❑ Yes ❑ No
d) ❑ Chronic Kidney Disease, ❑ Liver Disease, ❑ Gastrointestinal Disorders (e.g. Ulcers, GI Bleed, Bowel Obstruction, Hepatitis, Crohn's Disease, Colitis or Diverticular Disease)	❑ Yes ❑ No	❑ Yes ❑ No
e) ❑ Epilepsy, ❑ Seizures, or ❑ Syncope	❑ Yes ❑ No	❑ Yes ❑ No
f) Hospitalized as a result of a fall	❑ Yes ❑ No	❑ Yes ❑ No
g) ❑ Multiple Sclerosis (M.S.), ❑ Lou Gehrig's Disease, ❑ Parkinson's Disease, ❑ Dementia or Alzheimer's	❑ Yes ❑ No	❑ Yes ❑ No
3. Has it been more than 30 months since your last checkup with a physician?	❑ Yes ❑ No	❑ Yes ❑ No

Rate Category Determination

*If you answered **NO to all questions** in section E. (questions 1, 2, and 3) you **qualify for the Star rate category**.*
YES responses described below determine the other rate categories. Your rate category will be needed for section F. to calculate your premium.

Standard Rate	**YES** to **ONE** or **MORE** of these questions: **1a, 1c, 1d, 1e, 2d,** and/or **2e** **YES** to **1b** and **ONE** or **MORE** of **any question in 1, 2, or 3** **YES** to **2b** and/or **2f** and **ONE** or **MORE** of **any question in 1, 2, or 3**	**Select Rate**	**YES** to **TWO** or **MORE** of **2a, 2c, 2g,** and **3**
Standard+ Rate	**YES** to **ONE** of **1b, 2b,** or **2f;** or **BOTH 2b** and **2f**	**Select+ Rate**	**YES** to **ONE** of **2a, 2c, 2g,** or **3**

Applicant 1 Rate Category	Applicant 2 Rate Category
❑ Star ❑ Select+ ❑ Select ❑ Standard+ ❑ Standard	❑ Star ❑ Select+ ❑ Select ❑ Standard+ ❑ Standard

F. Plan Details & Rate Calculation *(See the TravelStar brochure on gms.ca for rates.)*

Complete this section based on your plan selection from section B. on page 1.

If purchasing Emergency Medical Coverage, use the Star rate category for applicants under 59, including dependants. Applicants 60 and over, use the rate category determined in section E. to calculate your premium.

Multi-Trip Annual Plan

Coverage Details	**Applicant 1** *15 or 30 Day Rate*	**Applicant 2** *15 or 30 Day Rate*	**Dependant(s)** *Total # of Dep. x 15 or 30 Day Rate*
F1. EMERGENCY MEDICAL COVERAGE			
Days of Coverage Per Trip *(Trip Length)* ❑ 15 Days ❑ 30 Days / Effective Date of Plan *(DD/MM/YYYY)*			
Deductible *(select one - applies to all applicants and must be the same for all emergency medical coverage being purchased)* ❑ $0 *(listed in brochure rate table)* ❑ $250 *(x rate by .9)* ❑ $1,000 *(x rate by .8)* ❑ $5,000 *(x rate by .7)*	$	$	$
F2. TRIP CANCELLATION COVERAGE *(only available with Multi-Trip Annual Emergency Medical Coverage)*	Sum Insured Premium	Sum Insured Premium	Total # of Dep. x Sum Insured Premium
Trip Cancellation Sum Insured Per Trip (*must be the same for all applicants*) ❑ $1,000 ❑ $2,500 ❑ $5,000	$	$	$
Add Trip Delay Upgrade? ❑ Yes ❑ No	$	$	$
An emergency medical premium discount applies when travelling with a spouse or dependant(s): 5% COMPANION DISCOUNT	$ ( )	$ ( )	$ ( )
A trip cancellation discount applies when purchasing with Emergency Medical Coverage: 10% BUNDLE DISCOUNT	$ ( )	$ ( )	$ ( )
If you are 16 or older and have used tobacco or tobacco products in the last 24 months add: 15% TOBACCO SURCHARGE	$	$	$
Saskatchewan residents purchasing Emergency Medical and/or Trip Cancellation Coverage add: 6% PST	$	$	$
Ontario (8%), Manitoba (8%), and Newfoundland (15%) residents purchasing Trip Cancellation Coverage add: RST	$	$	$
TOTAL	$	$	$

Single-Trip Plan

Coverage Details	**Applicant 1** *# of days x daily rate (based on total trip length)*	**Applicant 2** *# of days x daily rate (based on total trip length)*	**Dependant(s)** *Total # of Dep. x daily rate x No. of days*
F3. EMERGENCY MEDICAL COVERAGE *(no charge for children under 16, to a max. of 6 children, when travelling with a paying adult)*			
Are you topping up travel coverage from GMS or another provider? ❑ Yes ❑ No *If Yes, please complete the Top Up Information section below.*			
Top Up Information Who is your existing travel coverage with? ❑ GMS *Policy Number* _____ *Days of coverage under the plan* _____ ❑ Other *Insurance Provider* _____ *Days of coverage under the plan* _____			
Departure Date *(DD/MM/YYYY)* / Return Date *(DD/MM/YYYY)*			
Total Trip Length *(include Departure and Return Dates)*			
If purchasing this plan as a top up to existing insurance, this plan will go into effect on the day immediately after your existing coverage ends. Premium is based on the daily rate for the total trip length.			
Primary Destination *(where you will spend most of your time)*			
Deductible *(select one - applies to all applicants and must be the same for all emergency medical coverage being purchased)* ❑ $0 *(x rate by 1.1)* ❑ $250 *(listed in brochure rate table)* ❑ $1,000 *(x rate by .9)* ❑ $5,000 *(x rate by .8)*	$	$	$
F4. TRIP CANCELLATION COVERAGE	Sum Insured Premium	Sum Insured Premium	Total # of Dep. x Sum Insured Premium
Sum Insured/Trip Value Per Person *(can be different for each applicant)* Applicant 1:_____ Applicant 2:_____ Dependant(s): _____	$	$	$
Add Trip Delay Upgrade? ❑ Yes ❑ No	$	$	$
An emergency medical premium discount applies when travelling with a spouse or dependant(s): 5% COMPANION DISCOUNT	$ ( )	$ ( )	$ ( )
A trip cancellation discount applies when purchasing with Emergency Medical Coverage: 10% BUNDLE DISCOUNT	$ ( )	$ ( )	$ ( )
If you are 16 or older and have used tobacco or tobacco products in the last 24 months add: 15% TOBACCO SURCHARGE	$	$	$
Saskatchewan residents purchasing Emergency Medical and/or Trip Cancellation Coverage add: 6% PST	$	$	$
Ontario (8%), Manitoba (8%), and Newfoundland (15%) residents purchasing Trip Cancellation Coverage add: RST	$	$	$
TOTAL	$	$	$

G. Payment Options

Payment Amount *(Multi-Trip Annual Plan and/or Single-Trip Plan Total Premium for Applicant 1 + Applicant 2 + Dependants from page 3)*

Payment Method

❑ Cash ❑ Cheque ❑ Visa ❑ MasterCard

Credit Card Number	Security Code	Expiry Date *(MM/YY)*	Signature of Cardholder
			X

Coverage will be effective upon GMS' approval of the application and receipt of the appropriate premium.

H. Applicant Declaration

I affirm that I have authority to act on behalf of myself and all other persons listed on the application. I confirm the following declarations and authorizations on behalf of all listed persons.

It is understood and agreed that:

1. All statements made in the application are true and complete.
2. Any misrepresentation of, or incorrect or concealed information, may void the coverage.
3. Changes in health after applying must be reported to GMS and may affect eligibility for coverage or require an increase in premium.
4. Government health plan coverage must be in force and maintained throughout the duration of the plan.
5. Medical conditions must be stable for 180 days prior to your:
   a) departure date for coverage to be provided for the medical condition, if purchasing Emergency Medical Coverage; or
   b) purchase date to be covered for a cancellation or interruption, if purchasing Trip Cancellation Coverage.
6. If purchasing Trip Cancellation Coverage, any expenses related to events or situations you are aware of that might cause you to cancel your trip before you purchase, will not be covered.

For the purpose of administering the policy and/or verifying eligibility for benefits, authorization is provided for:

1. any physician, health care provider, other person, hospital or institution to release information to GMS and/or its authorized agents, representatives or affiliates concerning medical history, symptoms, treatment, examinations, diagnoses and/or services rendered; and
2. for GMS to collect, store and use any personal information provided to or disclosed by GMS between a Government health plan; any hospital, clinic or other health facility; a doctor or other health care provider; any insurance company; any other service provider or third party reasonably required to administer the policy in accordance with the GMS privacy policy available at www.gms.ca.

Signature of all Applicants and Dependant Applicants 18 years of age and older

Applicant 1 Signature X	Date *(DD/MM/YYYY)*
Applicant 2 Signature X	Date *(DD/MM/YYYY)*
Dependant 1 Signature X	Date *(DD/MM/YYYY)*
Dependant 2 Signature X	Date *(DD/MM/YYYY)*

IMPORTANT NOTICE
READ CAREFULLY BEFORE YOU TRAVEL

- Travel insurance covers claims arising from sudden and unforeseen circumstances.
- To qualify for this insurance, you must meet all the eligibility requirements.
- This insurance contains limitations and exclusions. Examples may include: medical conditions that are not stable, pregnancy, a child born on a trip, excessive use of alcohol, or high risk activities.
- This insurance may not cover claims related to pre-existing medical conditions and symptoms, including those that you have told us about.
- Contact GMS Assistance before seeking treatment or your benefits may be limited.
- In the event of a claim, your prior medical history may be reviewed.
- If you have been asked to complete a medical questionnaire and any of your answers are not accurate or complete, this policy may be voidable.

I. For Broker or Agent Use Only

The undersigned hereby confirms that appropriate disclosure, as set out in the Canadian Council of Insurance Regulators: Advisor Disclosure document, has been made to the client regarding: (a) the company or companies represented; (b) that a commission is received for sale of this insurance product; (c) that additional compensation may be received in the form of bonuses; (d) any conflict of interest with respect to this transaction.

Agent Signature X _____

Agent #1 | Agent #2 | Split A1% / A2% | For Office Use: | Effective Date: DD/MM/YYYY | GMS ID: