



460 Richmond Street West, Suite 100
Toronto, ON M5V 1Y1, Canada

Telephone: **1-800-360-3234**
Fax: **1-877-844-6453**

helpline@imagineinsurance.com
www.ingletravel.com

NOTE: Coverage is NOT available for Switzerland, Germany and Abu Dhabi state, in the United Arab Emirates (subject to change without notice).

For Office Use Only	BROKER 2837	POLICY NUMBER
----------------------------	-----------------------	---------------

Primary Applicant Information (Please print in block letters)

38 03 APP ECA 0911 000

(Mr, Mrs, Miss, Ms, Dr, Other)	First Name(s)	Last Name
Title D M Y	Sex M / F	Provincial Health Card Number (optional)
Date of Birth	Nationality on Passport(s)	Foreign Country of Residence
Occupation	Address	
Mailing Address (if different from the adjacent)	Telephone Number - Residence	
Telephone Number - Work	Fax Number	
E-mail Address	Emergency Contact: Name and Telephone Number	

Dependent Information - If there is insufficient space, please use a separate sheet and indicate that you have done so by ticking this box

	1 st Dependent	2 nd Dependent	3 rd Dependent	4 th Dependent
Last name				
First Name(s)				
Date of Birth (D/M/Y)				
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Foreign Country of Residence				
Nationality				
Relation to Applicant				
Occupation				

Family Physician Information

This section must be filled out completely. (If you do not have a family physician in Canada, please provide the information for the physician you visited most recently.)

Name(s) of General Practitioner(s)/Family Physician(s)	
Telephone Number(s)	
Fax Number(s)	
Address(es) of General Practitioner(s)/Family Physician(s)	

DECLARATION - A copy of this declaration shall be as valid as the original.

Part A – Pre-existing medical conditions

One year moratorium

I/we understand that any condition (except for a minor ailment as defined in the policy) for which the insured person(s) has sought or received medical treatment, advice, follow-up visits, counseling, or has taken prescription drugs within one hundred and eighty (180) days prior to becoming insured under this policy, will not be covered until a continuous period of not less than three hundred and sixty-five (365) consecutive days has passed during which time the insured person(s) has not sought or received medical treatment, advice, follow-up visits, counseling, nor has taken prescription drugs related to such condition.

Part B – Release of Medical Information

By signing this application, I also hereby direct and authorize any physician, health care practitioner, hospital or other medical care facility, pharmacy, the Ministry of Health or any other person who has attended and examined me or who has knowledge or records of me or my health, to furnish to European Benefits Administrators and to Global Excel Management Inc. any or all information with respect to my sickness, injury, medical history, consultations, medicines or treatment and copies of all health or medical records.

Part C - Disclosure

I/we shall read the policy wording and I/we understand it to be part of the Insurance Contract issued as a result of this application. To the best of my/our knowledge and belief, the information provided in connection with this application, whether in my/our own hand or not, is true and I/we have not withheld any material facts. I/we understand that non-disclosure or misrepresentation of any material fact may entitle the insurer to void the insurance. A material fact is one likely to influence acceptance or assessment of this application by the insurer. If I am/we are in any doubt as to whether a fact is material or not, I/we have disclosed it (on a separate sheet where necessary). This application and the information provided in connection therewith contains statements upon which the insurer will rely in deciding whether to accept this insurance and in determining the terms and conditions of such acceptance. I/we understand that the signing of this application does not bind me/us to complete, or the insurer to accept, this insurance.

 Primary Applicant's Signature: Date of Signature:

D	M	Y
---	---	---

Policy Dates (coverage cannot be confirmed before **etfs** receives this application).

Effective Date

D	M	Y
---	---	---

 You can choose 6, 9 or 12 months coverage by ticking the appropriate box.

6 months 9 months 12 months

Type of Coverage

Refer to the rate guide for premium options.

Worldwide coverage **excluding** the United States Worldwide coverage **including** the United States

Premium Calculation

PREMIUM PER APPLICANT						Subtotal				
Primary \$ <input style="width: 80px;" type="text"/>	+	1 st Dependent \$ <input style="width: 80px;" type="text"/>	+	2 nd Dependent \$ <input style="width: 80px;" type="text"/>	+	3 rd Dependent \$ <input style="width: 80px;" type="text"/>	+	4 th Dependent \$ <input style="width: 80px;" type="text"/>	=	\$ <input style="width: 100px;" type="text"/>
DEDUCTIBLE OPTIONS										
<input type="checkbox"/> NO Deductible (Automatic)										
<input type="checkbox"/> \$250 (Subtract 7% from premium)										
<input type="checkbox"/> \$500 (Subtract 12% from premium)										
<input type="checkbox"/> \$1,000 (Subtract 16% from premium)										
<input type="checkbox"/> \$5,000 (Subtract 27% from premium)										
PREMIUM PAYMENT OPTIONS & AMOUNTS										
<small>(Semi-annual and quarterly payment options are only available for the 12 month coverage.)</small>										
<input type="checkbox"/> Annually										
<input type="checkbox"/> Semi-annually (add 4% to premium)										
<input type="checkbox"/> Quarterly (add 8% to premium)										
TOTAL PREMIUM DUE										\$ <input style="width: 100px;" type="text"/>

Method of Payment

Visa MasterCard Amex Cheque made payable to **etfs**.
You must provide **etfs** with all post dated cheques for semi-annual or quarterly payment.

	M	Y		D	M	Y
Card Number	Expiry Date		Signature of Cardholder	Date Signed		