



The product described is subject to change without notice.

Age 54 or under
Effective September 15, 2009

For more information CALL 1-800-360-3234 or visit Ingle online at www.ingletravel.com
Please send your completed application and your cheque payable to:



Ingle International & Imagine Financial Ltd.
460 Richmond Street West, Suite 100
Toronto, Ontario M5V 1Y1

Header section with fields for APPLICANT 1 and APPLICANT 2, including Policy Number and Date issued (D/M/Y).

PERSONAL INFORMATION
Your personal information is collected for the purpose of providing you with insurance services, claims analysis and payments. Call 1-888-830-7460 for a copy of the etfs Privacy Policy.

STEP 1 ELIGIBILITY CRITERIA

- You must meet the following criteria to be eligible for this insurance:
1. You must be a Canadian resident and be covered by the government health insurance plan (GHIP) of your Canadian province or territory of residence for the entire duration of your trip;
2. You must NOT be travelling against the advice of a physician or have been diagnosed with a terminal illness or metastatic cancer.
3. You must NOT have a kidney disease requiring dialysis;
4. You must NOT have been prescribed or used home oxygen during the 12 months prior to your departure date;
5. You must NEVER have been diagnosed with AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus).
6. You must complete and submit this Application prior to the effective date of insurance.

STEP 2 DEFINITIONS - Please refer to the following definitions for words where notations appear in this application.

- 1. Minor Ailment means any sickness or injury which does not require: the use of medication for a period of greater than 15 days; more than one follow-up visit to a physician, hospitalization, surgical intervention, or referral to a specialist; and which ends at least 30 consecutive days prior to the departure date of each trip.
2. Stable means any medical condition (other than a minor ailment!) for which all the following statements are true:
a. there has been no new diagnosis, treatment or prescribed medication;
b. there has been no change in treatment or change in medication, including the amount of medication to be taken, how often it is taken, the type of medication or change in treatment frequency or type.
3. Treated means that you have been hospitalized, have been prescribed medication (including prescribed as needed), have taken or are currently taking medication or have undergone a medical or surgical procedure.
Exceptions: the routine adjustment of Coumadin, Warfarin, insulin or oral medication to control diabetes (as long as they are not newly prescribed or stopped) and a change from a brand name medication to a generic brand medication (provided that the dosage is not modified);
c. there have been no new symptoms, more frequent symptoms or more severe symptoms;
d. there have been no test results showing deterioration;
e. there has been no hospitalization or referral to a specialist (made or recommended) and you are not awaiting the results of further investigations for that medical condition.

STEP 3 PRE-EXISTING MEDICAL CONDITION EXCLUSIONS

- For the full pre-existing medical condition exclusions, refer to your policy.
This insurance does not cover losses or expenses caused directly or indirectly, in whole or in part by:
1. Any sickness, injury or medical condition (other than a minor ailment!) that was not stable at any time during the 180 days (90 days for high blood pressure) prior to each departure date.
2. Any lung condition for which you required hospitalization, the use of home oxygen therapy or treatment with oral steroids (e.g. prednisone) at any time during the 365 days prior to each departure date;
3. any heart condition which was not stable at any time during the 365 days prior to each departure date;
4. congestive heart failure if you have ever been diagnosed or treated for congestive heart failure; or
5. any of the following conditions if you have been diagnosed or treated for a total of three or more of these conditions at any time during the 365 days prior to each departure date: any heart condition, any lung condition, high blood pressure or diabetes treated with oral medication and/or insulin.

STEP 4 PLAN INFORMATION - In addition to our Single Trip Daily and Multi-Trip Annual Plans, this insurance also offers:

- 1. 40-day Supplemental Multi-Trip Annual Plan for the Public Service Health Care Plan (PSHCP) members: Increase your coverage amount (either \$100,000 or \$500,000) to \$5 million CAD and be covered for Trip Cancellation, Interruption and Delay benefits up to \$4,000 CAD. Also be covered for benefits not offered by the PSHCP, such as Vehicle Return or Emergency Relief of Dental Pain from the first dollar. See your policy for the full pre-existing medical exclusion.
2. Canada Plan: Provides coverage for a single trip while travelling outside your province or territory of residence but within Canada for the entire duration of your trip. You can benefit from great rates with a \$0 deductible. Please refer to the rate sheet for details.

STEP 5 GENERAL INFORMATION

Form section for APPLICANT 1 and APPLICANT 2, including fields for Last Name, First Name, Date of Birth (Day/Month/Year), and checkboxes for Male and Female.



**STEP 5 GENERAL INFORMATION (continued)**

**HOME ADDRESS:** Street: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_  
 Postal Code: \_\_\_\_\_ E-mail: \_\_\_\_\_ Tel.: ( ) \_\_\_\_\_

**DESTINATION ADDRESS:** Street: \_\_\_\_\_ City: \_\_\_\_\_ Province/State: \_\_\_\_\_  
 Postal/Zip Code: \_\_\_\_\_ E-mail: \_\_\_\_\_ Tel.: ( ) \_\_\_\_\_  
 Emergency Contact Name: \_\_\_\_\_ Tel.: ( ) \_\_\_\_\_

If applying for **family coverage**, please list the last name, first name and date of birth for each dependent. If additional space is required, please attach an additional sheet of paper.

	Last Name	First Name	Date of Birth (D/M/Y)	Male	Female
1.	_____	_____	D M Y	<input type="checkbox"/>	<input type="checkbox"/>
2.	_____	_____	D M Y	<input type="checkbox"/>	<input type="checkbox"/>
3.	_____	_____	D M Y	<input type="checkbox"/>	<input type="checkbox"/>

**STEP 6 TRIP INFORMATION**

	APPLICANT 1	APPLICANT 2
<b>PLAN TYPE</b>		
<b>Multi-Trip Annual Plan</b>	<input type="checkbox"/> 9 days <input type="checkbox"/> 16 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 40-day PSHCP Supplemental Effective Date (D/M/Y): ____/____/____	<input type="checkbox"/> 9 days <input type="checkbox"/> 16 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 40-day PSHCP Supplemental Effective Date (D/M/Y): ____/____/____
<b>All-Inclusive Multi-Trip Annual Plan</b>	<input type="checkbox"/> 9 days <input type="checkbox"/> 16 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days Effective Date (D/M/Y): ____/____/____	<input type="checkbox"/> 9 days <input type="checkbox"/> 16 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days Effective Date (D/M/Y): ____/____/____
<b>Single Trip Daily Plan</b>	<input type="checkbox"/> Daily Plan <input type="checkbox"/> Canada Plan <input type="checkbox"/> Non-Medical Supplement Departure Date (D/M/Y): ____/____/____ *Effective Date (D/M/Y): ____/____/____ Expiry Date (D/M/Y): ____/____/____	<input type="checkbox"/> Daily Plan <input type="checkbox"/> Canada Plan <input type="checkbox"/> Non-Medical Supplement Departure Date (D/M/Y): ____/____/____ *Effective Date (D/M/Y): ____/____/____ Expiry Date (D/M/Y): ____/____/____

\* If you are adding the Daily Plan as a top up to an existing coverage, the Effective Date will be the day after your existing coverage terminates.

Please indicate the name of the other insurer: \_\_\_\_\_ and the number of days: \_\_\_\_\_

**STEP 7 PREMIUM CALCULATION AND METHOD OF PAYMENT**

	APPLICANT 1	APPLICANT 2
<b>PLEASE REFER TO THE RATE SHEET FOR THE PREMIUMS.</b>		
<b>1. Multi-Trip Annual or All-Inclusive Multi-Trip Annual</b>		
a) Your premium from the respective rate table: <i>located on your rate sheet</i> . . . . . a)	\$ _____	a) \$ _____
b) For the <u>All-Inclusive Multi-Trip Annual Plan</u> , calculate the appropriate tax portion based on line a) (Ontario 8%, Québec 9%): <i>Tax x line a)</i> . b)	\$ _____	b) \$ _____
c) Multi-Trip Annual Subtotal: <i>line a) + line b)</i> . . . . .	\$ _____	\$ _____
<b>2. Single Trip Daily and/or Top Up</b>		
a) Total trip duration . . . . . a)	_____ days	a) _____ days
b) Existing coverage, if applicable . . . . . b)	_____ days	b) _____ days
c) Travel days covered by a Single Trip Daily Plan: <i>line a) – line b)</i> . . . . . c)	_____ days	c) _____ days
d) Single Trip Daily Plan rate based on total trip duration: <i>located on your rate sheet</i> . . . . . d)	\$ _____	d) \$ _____
e) Single Trip Daily and/or Top Up Subtotal: <i>line c) x line d)</i> . . . . . e)	\$ _____	\$ _____
<b>3. Non-Medical Supplement</b>		
a) \$CAD value of Non-Medical coverage required (rounded to the next \$100) . . . . . a)	\$ _____	a) \$ _____
b) Divide line a) by 100: <i>line a) ÷ 100</i> . . . . . b)	_____	b) _____
c) Non-Medical Supplement rate based on your age: <i>located on your rate sheet</i> . . . . . c)	\$ _____	c) \$ _____
d) Non-Medical Premium: <i>line b) x line c)</i> . . . . . d)	\$ _____	d) \$ _____
e) Calculate the appropriate tax portion based on line d) (Ontario 8%, Québec 9%): <i>Tax x line d)</i> . e)	\$ _____	e) \$ _____
f) Non-Medical Supplement Subtotal: <i>line d) + line e)</i> . . . . . f)	\$ _____	\$ _____
4. Subtotal of lines 1 to 3: <i>line 1 c) + line 2 e) + line 3 f)</i> . . . . .	\$ _____	\$ _____
5. Travel Companion Discount: If applicable, subtract 5% from line 4 for the respective applicants (refer to rate sheet for details): <i>0.95 x line 4</i> . . . . .	\$ _____	\$ _____
6. Top Up Surcharge: Indicate \$25 if you are topping up another carrier's coverage . . . . .	\$ _____	\$ _____
<b>7. TOTAL TRAVEL INSURANCE PREMIUM: line 5 + line 6</b> . . . . .	\$ _____	\$ _____
(The minimum premium is \$25 per person, per plan)		
<b>TOTAL PAYMENT SUBMITTED FOR APPLICANT 1 AND APPLICANT 2</b> . . . . .	\$ _____	

**METHOD OF PAYMENT:**  Visa  MasterCard  AMEX  Diners - En Route  Cheque made payable to the broker or sales agent indicated on the front of this application.

\_\_\_\_\_

Card Number Expiry Date (M/Y) Signature of Cardholder Date Signed (D/M/Y)