

IMPORTANT DEFINITIONS*:

Cancer* or Carcinoma refers to any malignant tumor or abnormal new cell growth or rapid growth in any organ of the body, which has a probability of spreading to other organs through direct extension or through the lymphatic system (lymph nodes), and is usually treated by surgical resection, radiation therapy, and chemotherapy. Metastatic cancer is when the *cancer** has spread from the originating place to another place in the body.

Cardiovascular Condition* means any structural or functional abnormality related to the heart, blood vessels (arteries or veins) and the circulating blood.

Heart Condition* means any abnormality of any part of the heart (including the blood vessels supplying the heart, heart valves, and pericardium) that impairs the heart's normal functioning. Examples include atrial fibrillation, coronary artery disease and congestive heart failure.

Lung Condition* means any structural or functional abnormality involving your lungs (including COPD - Chronic Obstructive Pulmonary Disease).

Medical Check-up* means an annual physical exam, personal health visit or a routine visit to a physician or nurse practitioner where a complete medical examination is conducted, your medical history is updated, a physical examination is done, any symptoms were diagnosed, and any screening or relevant tests were recommended.

Medical Condition* means sickness or injury (or condition related to that sickness or injury) that required or requires medical advice, consultation, investigation, treatment, care, service or diagnosis by a medical professional.

Medical Emergency* means the unforeseen and emergent occurrence of symptoms for a sickness or injury which, unless treated immediately by a physician, may lead to death or to serious impairment of your health.

Medical Treatment* means any reasonable procedure which is medical, therapeutic or diagnostic in nature, which is medically necessary and which is prescribed by a physician. *Medical treatment** includes hospitalization, basic investigative testing, *surgery**, prescription medication(s) (including prescribed as needed) or other treatment directly related to the sickness, injury or symptom.

Neurological Condition* means any structural or functional abnormality of the central nervous system (brain) and the peripheral nervous system (nerves).

Respiratory Condition* means any structural or functional abnormality of your airways, lungs, and chest muscles or bones supporting breathing.

Smoker* means a person who uses nicotine in any form, including cigarettes, cigars, chewing tobacco, a nicotine patch, nicotine gum or nicotine capsules for use in vapor cigarettes.

Surgery* means a surgical procedure or operation that required the patient to be hospitalized overnight. Examples include knee or hip replacement, cardiovascular *surgery**, gastric bypass and gastric banding.



YOU MUST READ THESE INSTRUCTIONS CAREFULLY BEFORE COMPLETING YOUR MEDICAL QUESTIONNAIRE.

ELIGIBILITY:

You are not eligible for any coverage under this policy if your trip is booked or undertaken:

- contrary to medical advice;
- while you require kidney dialysis;
- after receiving diagnosis of terminal illness with less than 6 months to live;
- if you have ever had an organ transplant (except cornea transplant);
- if you have been diagnosed with and/or received *medical treatment** for metastatic *cancer** in the last 5 years;
- if you have been prescribed or taken home oxygen for a *lung condition** in the last 12 months.

INSTRUCTIONS TO THE APPLICANT:

1. Only **YOU**, the applicant, can complete and sign your Medical Questionnaire, not your spouse or agent. **Mistakes cannot be initialled. Please complete another Medical Questionnaire.**
2. Any errors in answering questions on the Medical Questionnaire (if required) specifically related to a claim will result in you paying the first \$5000 CAD of any claim and the additional premium required based on true and accurate answers. Any willful errors or omission could result in the policy being voided.
3. Coverage for a medical condition that existed before your policy starts requires a stability period of 3 or 6 months, depending on your age. The condition(s) must be **stable** prior to the departure date of each trip you take.
4. Please refer to your policy for complete details of the benefits, conditions, limitations, exclusions and definitions applicable to the insurance purchased.

PRIVACY AND CONFIDENTIALITY

The specific and detailed information requested on the Medical Questionnaire is required to process your application for travel insurance and will be used to establish and serve you as our customer. You may contact Orion Travel Insurance Company with any questions relating to the use of your personal information by writing to: Privacy Officer, Orion Travel Insurance Company, 60 Commerce Valley Drive East, Thornhill, Ontario L3T 7P9.

Name: _____

Date of Birth: _____ Policy Number: _____

DD/MM/YYYY

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PART A – PLEASE COMPLETE		YES	NO
1.	Has it been more than 18 months since your last regular <i>medical check-up</i> ?	<input type="radio"/>	<input type="radio"/>
2.	In the last 12 months have you had more than one visit to a hospital emergency room for a <i>medical emergency</i> ?	<input type="radio"/>	<input type="radio"/>
3.	In the last 5 years have you been a <i>smoker</i> ?	<input type="radio"/>	<input type="radio"/>
4.	In the last 12 months have you had <i>surgery</i> (including hip or knee replacement, gastric bypass or gastric banding)?	<input type="radio"/>	<input type="radio"/>
5.	Have you ever required <i>medical treatment</i> or taken ANY prescription medications for:		
a.	<i>Cardiovascular condition</i> (including high blood pressure)?	<input type="radio"/>	<input type="radio"/>
b.	Diabetes?	<input type="radio"/>	<input type="radio"/>
c.	<i>Cancer</i> (excluding basal cell and squamous cell)?	<input type="radio"/>	<input type="radio"/>
d.	<i>Neurological condition</i> (including stroke)?	<input type="radio"/>	<input type="radio"/>
e.	<i>Respiratory condition</i> (including COPD or use of puffers/inhalers)?	<input type="radio"/>	<input type="radio"/>
6.	In the last 12 months have you had any other <i>medical condition</i> or been prescribed or taken ANY other prescription medications?	<input type="radio"/>	<input type="radio"/>

If you answered **YES** to any part of Question 5 or Question 6, please continue to the appropriate section(s) in **PART B**, otherwise proceed to **PART C**.

PART B – CARDIOVASCULAR (Complete only if YES to Question 5a.)		YES	NO
7.	Have you ever had a heart bypass or heart valve <i>surgery</i> ?	<input type="radio"/>	<input type="radio"/>
8.	Have you ever had angioplasty or a stent inserted?	<input type="radio"/>	<input type="radio"/>
9.	In the last 12 months have you been prescribed or taken:		
a.	Lasix or Furosemide?	<input type="radio"/>	<input type="radio"/>
b.	Coumadin or Warfarin?	<input type="radio"/>	<input type="radio"/>
10.	In the last 12 months have you required <i>medical treatment</i> or taken ANY prescription medications for:		
a.	Congestive heart failure?	<input type="radio"/>	<input type="radio"/>
b.	<i>Heart condition</i> ?	<input type="radio"/>	<input type="radio"/>
c.	High blood pressure (hypertension)?	<input type="radio"/>	<input type="radio"/>
d.	Peripheral vascular disease (atherosclerosis or deep vein thrombosis)?	<input type="radio"/>	<input type="radio"/>
e.	Aneurysm?	<input type="radio"/>	<input type="radio"/>


PART B – DIABETES (Complete only if YES to Question 5b.)		YES	NO
11.	In the last 5 years have you required <i>medical treatment</i> or taken ANY prescription medications for Diabetes (excluding when controlled with diet only)?	<input type="radio"/>	<input type="radio"/>

PART B – CANCER (Complete only if YES to Question 5c.)		YES	NO
12.	Have you required <i>medical treatment</i> (including <i>surgery</i> , chemotherapy or radiation) for <i>cancer</i> in the last:		
a.	0 to 6 months?	<input type="radio"/>	<input type="radio"/>
b.	7 to 12 months?	<input type="radio"/>	<input type="radio"/>
c.	13 months to 5 years?	<input type="radio"/>	<input type="radio"/>

PART B – NEUROLOGICAL (Complete only if YES to Question 5d.)		YES	NO
13.	In the last 5 years have you required <i>medical treatment</i> or taken ANY prescription medications for:		
a.	Parkinson's Disease?	<input type="radio"/>	<input type="radio"/>
b.	Alzheimer's disease or ANY other form of Dementia?	<input type="radio"/>	<input type="radio"/>
c.	Stroke/CVA (Cerebrovascular Accident) or mini-stroke/TIA (Transient Ischemic Attack)?	<input type="radio"/>	<input type="radio"/>

PART B – RESPIRATORY (Complete only if YES to Question 5e.)		YES	NO
14.	In the last 12 months have you been prescribed or taken Prednisone for ANY <i>medical condition</i> ?	<input type="radio"/>	<input type="radio"/>
15.	In the last 5 years have you required <i>medical treatment</i> or taken ANY prescription medications for a <i>lung condition</i> ?	<input type="radio"/>	<input type="radio"/>

PART B – OTHER MEDICAL CONDITION (Complete only if YES to Question 6.)		YES	NO
16.	In the last 12 months have you required <i>medical treatment</i> or taken ANY prescription medications for:		
a.	Gastroesophageal reflux disease (GERD)?	<input type="radio"/>	<input type="radio"/>
b.	Diverticular disorder?	<input type="radio"/>	<input type="radio"/>
c.	Chronic bowel disorder (including Crohn's Disease or Colitis)?	<input type="radio"/>	<input type="radio"/>
d.	Kidney or gall bladder disorder (including stones)?	<input type="radio"/>	<input type="radio"/>
e.	Liver or pancreas disorder?	<input type="radio"/>	<input type="radio"/>

PART C – AGREEMENT, UNDERSTANDING AND AUTHORIZATION	
	I confirm I have read and understood the Eligibility, Instructions to Applicant and Definitions sections of this Medical Questionnaire prior to its completion. I personally completed this Medical Questionnaire and all information disclosed on it is true and accurate. I fully understand that if any of my answers are untrue or incorrect, any coverage offered will be null and void.
I understand Orion Travel Insurance Company, AMA employees, its agents, third party administrators or its legal representatives may investigate any claim. I authorize any hospital, physician, other medical service provider, or any other organization or person that has any records or knowledge of me and my health to release to third party administrators, Orion Travel Insurance Company and its reinsurers any such information for the purpose of this application and contract and any subsequent claim.	
Applicant's Signature _____	Date of Application _____
DD/MM/YYYY	