



Thank you for your continued interest in our travel insurance program.

Our goal is to provide an insurance plan for every client's needs. That is why we offer a program where medical conditions can be assessed individually by our underwriting staff.

Since you have indicated interest in our Medical Underwriting Plan, we have enclosed a medical questionnaire that your attending physician must fill out, not more than 90 days prior to your departure date.

This medical questionnaire (Form 1) will help determine your eligibility for coverage under the Medical Underwriting Plan. As the applicant, please complete Part A **ONLY** (client information). Your physician must complete the remaining sections (Parts B through E). Your physician must also sign and date the completed questionnaire before it is returned. Should your physician levy a charge for the completion of the questionnaire, it is your responsibility to pay that charge.

To ensure the timely review of your medical questionnaire, make sure that you return the signed form by fax at 819-566-8067 or to the following address:

RSA

c/o Medical Underwriting Department
2665 King Ouest, Suite 650
Sherbrooke, QC J1L 2G5

If you have any questions, please do not hesitate to contact one of our qualified customer service representatives who are available to answer your questions Monday to Friday from 8 a.m. to 8 p.m. and Saturday from 9 a.m. to 5 p.m. (ET).

Medical Underwriting Plan



Form 1 - Application and Medical Questionnaire (to be completed by the physician)

For Broker/Sales Agent use only:

Company Name: _____ Contact Person: _____
 Tel. Number: _____ Fax Number: _____ E-mail: _____

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Part A CLIENT INFORMATION

Name: _____ Date of Birth (d/m/y): / /
 Address: _____
 Tel. Number: _____ Fax Number: _____ E-mail: _____
 Travel Dates Departure (d/m/y): / / Return (d/m/y): / / Trip Duration: days
 Exact Destination City: _____ State: _____ Country: _____

IMPORTANT NOTICE

Important Notice About Your Personal Information: By submitting this application you agree that Royal & Sun Alliance Insurance Company of Canada (“we”, “us”) may collect, use and disclose your Personal Information (including to and from your broker, our affiliates and service providers and organizations that may have referred you to us, and professional associations of which you may be a member) for purposes of quoting a premium, policy administration, improving customer experience, administering referral arrangements, and for other lawful purposes described in our Protecting Customer Privacy document. For a copy of this document please see www.rsatravelinsurance.com.

Part B MESSAGE TO THE PHYSICIAN

Filling out this questionnaire* will assist your patient to obtain the proper emergency medical insurance while he or she is travelling. Proper coverage will safeguard your patient’s financial security.

Although your patient does not qualify for our regular insurance plan, the answers you provide regarding your patient’s health status may enable us to offer a modified travel insurance plan.

Please include any additional relevant information that may help in our assessment. Do not include any results of genetic testing.

If you feel your patient should not be travelling, please discuss this matter with him or her and advise us in Part D - Comments. We appreciate your cooperation.

***IMPORTANT: Charges levied for the completion of this document remain your patient’s responsibility.**

Part C MEDICAL QUESTIONNAIRE (Please type or print clearly)

List all diagnoses and medical and/or surgical conditions	Date of initial presentation	List all current medications	Date of initial prescription	Medication changes (including dosage and date) in the last 12 months	
				Medication	Dates (d/m/y)

1. Has your patient taken **Lasix** or other diuretic in the last 5 years?

yes no If yes, please provide date & dosage: _____

If so, for what condition? CHF HTN Peripheral Edema Other (please specify): _____

2. Does your patient take an **ACE-inhibitor**?

yes no

If so, for what condition? CHF HTN Other (please specify): _____

3. List any other therapy required during the past 3 years (e.g. home oxygen, chemotherapy, radiation therapy, etc.).

Therapy: _____ Date or period of treatment (d/m/y): ____ / ____ / ____

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Therapy: _____ Date or period of treatment (d/m/y): ____ / ____ / ____

4. List all hospitalizations during the past 3 years.

Date of hospitalization (d/m/y): ____ / ____ / ____ Diagnosis: _____

Date of hospitalization (d/m/y): ____ / ____ / ____ Diagnosis: _____

Date of hospitalization (d/m/y): ____ / ____ / ____ Diagnosis: _____

5. List all major tests and investigations during the past 2 years (e.g. cardiac stress test, cardiac catheterization, scans). **Please include a copy of the test results.**

List other recent significant tests (e.g. Hgb for anemia, creatinine for renal insufficiency, LFTs for cirrhosis, etc.).

Test/investigation: _____ Date (d/m/y): ____ / ____ / ____ Results: _____

Test/investigation: _____ Date (d/m/y): ____ / ____ / ____ Results: _____

Test/investigation: _____ Date (d/m/y): ____ / ____ / ____ Results: _____

Ejection fraction (if known): ____ % Date (d/m/y): ____ / ____ / ____ **Smoking status:** yes no

6. Is the patient awaiting investigations, surgery or any other treatment?

yes no If so, please specify the **type** and the **date** (d/m/y): _____

7. Has your patient ever undergone a **Coronary Artery Bypass Graft**?

yes no Date (d/m/y): ____ / ____ / ____

Angioplasty?

yes no Date (d/m/y): ____ / ____ / ____

Stenting?

yes no Date (d/m/y): ____ / ____ / ____

8. Has the patient ever had a functional **cardiac classification** for **Angina**?

yes no

If so, what is the patient's **CURRENT class** of **Angina**? I II III IV Date of last episode (d/m/y): ____ / ____ / ____

9. Has the patient ever been diagnosed or treated for **Congestive Heart Failure**?

yes no

If so, what is the patient's **CURRENT class** of **Congestive Heart Failure**? I II III IV Date of last episode (d/m/y): ____ / ____ / ____

Part D

COMMENTS

Part E

PHYSICIAN INFORMATION

How long has the applicant been your patient (d/m/y)? ____ / ____ / ____ Are you this patient's family physician, specialist or other? _____

Physician's Name: _____

Address: _____

Physician's License Number: _____ Tel. Number: _____ Fax Number: _____

PHYSICIAN'S SIGNATURE: _____ **DATE (d/m/y):** ____ / ____ / ____

This form must be returned to: **RSA c/o Medical Underwriting, 2665 King Ouest, Suite 650, Sherbrooke, Quebec J1L 2G5**

Tel.: 1-800-680-3837 Fax: 819-566-8067