

Travel Insurance Application Form

Travel Plan 3

SECTION 1 MEMBER INFORMATION > Please print		For internal use only: ID NUMBER
First Name(s)	Initials	Last Name
Address - Street/Apt		
City/Town	Province	Postal Code
Date of Birth (DD/MM/YYYY)	Gender ☐ Male ☐ Female	
Contact Telephone Number (Home)	Contact Telephone Number (Work/Cell)	
E-mail Address	I wish to receive the following by e-mail ☐ Policy Information ☐ belairdirect Communications	
Name of Your Employer/Association	Membership Number (If applicable)	

SECTION 2 SPOUSE INFORMATION > Please print (Complete if spouse is applying for coverage)		
First Name(s)	Initials	Last Name
Date of Birth (DD/MM/YYYY)	Gender ☐ Male ☐ Female	

SECTION 3 DEPENDENT INFORMATION > Please complete if applying for Family Coverage (2 Single Plans also = Family Coverage)				
	First Name	Last Name	Date of birth (DD/MM/YYYY)	Gender (M/F)
Dependent				
Dependent				
Dependent				

SECTION 4 ELIGIBILITY
To be covered under the policy, you must meet the following eligibility requirements: - You must be covered under the government health insurance plan of your province; and - You must have your permanent residence in Canada; and - The required premium payments for your coverage under the policy must have been paid; and - You must be a member in good standing in accordance with the sponsoring organization or group's guidelines, or a spouse or dependent of such member. A dependent may be covered under family coverage but cannot apply for coverage under this insurance individually. ☐ I confirm that all persons listed in Sections 1, 2 and 3 are eligible for this insurance.

SECTION 5 COVERAGE SELECTION

1. I would like to apply for the following coverage for the plan indicated below: ☐ Individual ☐ Family
2. My spouse would also like to apply for the following coverage for the plan indicated below: ☐ Individual

Check the appropriate boxes and complete the details as required:

- ☐ **BASE PLAN** - unlimited number of trips. Trips outside Canada are limited to ☐ 17 or ☐ 35 consecutive days **OR**
- ☐ **SUPPLEMENTAL PLAN** - for a single trip of longer than 35 consecutive days outside of Canada. The 35-day Base Plan coverage is automatically included for the entire policy year.

Check the appropriate duration for the single trip of longer than 35 consecutive days outside of Canada, including the date you first leave Canada for a period of more than 35 consecutive days and the date you return to your province or territory of residence.

- ☐ 45 days ☐ 60 days ☐ 75 days ☐ 90 days ☐ 105 days ☐ 120 days ☐ 135 days
- ☐ 150 days ☐ 165 days ☐ 182 days

SECTION 6 TRAVEL INFORMATION > Please complete if you have selected the Supplemental Plan

PLEASE PRINT CLEARLY

TRIP # 1	Date of departure from Canada (DD/MM/YYYY) 	Date of return to your home province or territory (DD/MM/YYYY)
TRIP # 2	Date of departure from Canada (DD/MM/YYYY) 	Date of return to your home province or territory (DD/MM/YYYY)

GENERAL EXCLUSIONS 1, 2, 3 & 4

Additional exclusions and definitions apply. Refer to the policy for the complete details on exclusions and limitations.

Under your Emergency Medical Travel Insurance benefits, the Insurer will not pay any expenses relating to or in any way associated with:

1. Any medical condition (other than a minor ailment) that was not **stable*** at any time during the 90 days before your departure date.
2. Any medical condition that required the use of home oxygen at any time during the 90 days before your departure date.
3. Any cancer for which you received chemotherapy treatment at any time during the 90 days before your departure date.
4. Any lung condition that required treatment with oral steroids (prednisone or prednisolone) at any time during the 90 days before your departure date.

Under your Trip Cancellation and Trip Interruption Insurance, the Insurer will not pay any expenses relating to, or in any way associated with:

1. Any medical condition (other than a minor ailment) that was not **stable*** at any time during the 90 days before your booking date (for Trip Cancellation) or your departure date (for Trip Interruption and Delay).
2. Any medical condition that required the use of home oxygen at any time during the 90 days before your booking date (for Trip Cancellation) or your departure date (for Trip Interruption and Delay).
3. Any cancer for which you received chemotherapy treatment at any time during the 90 days before your booking date (for Trip Cancellation) or your departure date (for Trip Interruption and Delay).
4. Any lung condition that required treatment with oral steroids (prednisone or prednisolone) at any time during the 90 days before your booking date (for Trip Cancellation) or your departure date (for Trip Interruption and Delay).

Exclusions 1, 2, 3 and 4 apply to you, as well as your immediate family member, your travel companion, your travel companion's immediate family member, your business partner, your close friend, your key employee, your caregiver, or your host at your trip destination.

***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. "Change in medication" does not include: the routine adjustment of Coumadin, Warfarin, insulin or oral medication to control diabetes, or a change from a brand medication to a generic brand medication (where there is no modification to the dosage);
- c) there have been no new symptoms, more frequent symptoms or more severe symptoms;
- d) there have been no test results showing deterioration; and
- e) there has been no hospitalization or referral to a specialist (made or recommended) and no waiting of results of further investigations for that medical condition.

SECTION 7**HEALTH OPTION SELECTION** ➤ Health Option Questionnaire

To determine if you qualify for the Category A or Category B Health Option please complete the following questions.

If you have any questions about how you should answer the questionnaire, please contact your physician.
Yes or No answers **ONLY** and any changes **MUST** be initialed.

STEP 1 ➤ Health Option Questionnaire

	Member		Spouse	
	Yes	No	Yes	No
1. Have you ever in your lifetime, been diagnosed with, or have you taken medication or been prescribed medication or received treatment for ANY of the following:				
a) heart condition,	☐	☐	☐	☐
b) lung condition (except an acute infection not requiring ongoing physician care or medication),	☐	☐	☐	☐
c) high/low blood pressure,	☐	☐	☐	☐
d) diabetes (treated with oral medication or insulin or controlled by diet),	☐	☐	☐	☐
e) aneurysm,	☐	☐	☐	☐
f) stroke, CVA (cerebrovascular accident), mini-stroke, TIA (transient ischemic attack),	☐	☐	☐	☐
g) narrowing or blockage of any artery or blood vessel (including peripheral vascular disease (PVD)),	☐	☐	☐	☐
h) Alzheimer's disease/dementia,	☐	☐	☐	☐
i) bowel obstruction, chronic bowel disease, bowel surgery,	☐	☐	☐	☐
j) gastrointestinal bleeding,	☐	☐	☐	☐
k) liver disorder,	☐	☐	☐	☐
l) pancreatic disease,	☐	☐	☐	☐
m) kidney disease (including kidney stones), or	☐	☐	☐	☐
n) cancer (except basal cell and squamous cell skin cancer)?	☐	☐	☐	☐
2. In the past 60 months (5 years) have you used any tobacco product?	☐	☐	☐	☐
3. Was your last regular check-up with a physician or with a licensed nurse practitioner more than 18 months ago?	☐	☐	☐	☐

If you answer NO to ALL of the questions in Step 1, you qualify for the Category A Health Option. Continue to SECTION 8.

STEP 2 ➤ Health Option Questionnaire

	Member		Spouse	
	Yes	No	Yes	No
4. Have you ever in your lifetime, taken medication, or been prescribed medication, or received treatment for a heart condition?	☐	☐	☐	☐
5. Are you currently taking or have you been prescribed medication for diabetes and/or blood pressure , either to control or prevent diabetes and/or high/low blood pressure ?	☐	☐	☐	☐
6. In the past 5 years, have you been diagnosed with or have you taken medication or been prescribed medication or received treatment for:				
a) stroke, CVA (cerebrovascular accident), mini-stroke, TIA (transient ischemic attack), or	☐	☐	☐	☐
b) cancer (except basal cell and squamous cell skin cancer, or breast cancer treated only with Tamoxifen, Femara or Arimidex in the past 5 years)?	☐	☐	☐	☐
7. In the past 24 months, have you been diagnosed with or have you taken medication or been prescribed medication or received treatment for ANY of the following:				
a) lung condition (except an acute infection not requiring hospitalization, ongoing physician care or ongoing medication),	☐	☐	☐	☐
b) aneurysm,	☐	☐	☐	☐
c) Alzheimer's disease/dementia,	☐	☐	☐	☐
d) bowel obstruction, chronic bowel disease, bowel surgery,	☐	☐	☐	☐
e) gastrointestinal bleeding,	☐	☐	☐	☐
f) narrowing or blockage of any artery or blood vessel (including peripheral vascular disease (PVD)),	☐	☐	☐	☐
g) liver disorder,	☐	☐	☐	☐
h) pancreatic disease, or	☐	☐	☐	☐
i) kidney disease (including kidney stones)?	☐	☐	☐	☐
8. Was your last regular check-up with a physician or with a licensed nurse practitioner more than 24 months ago?	☐	☐	☐	☐

If you answer NO to ALL of the questions in Step 2, you qualify for the Category B Health Option.
If you answered YES to ANY of the questions in Step 2, you qualify for the Category C Health Option.
Continue to SECTION 8.

SECTION 8

AGREEMENTS AND AUTHORIZATIONS ➤ EACH applicant must read and agree by signing in the appropriate area below.

This insurance may not cover claims related to medical conditions that are not stable, whether disclosed or not at time of policy purchase. Additional information can be found on page 2 of this application. I will refer to the policy for complete details on exclusions and limitations.

- a) Where I was unsure of my medical history as it relates to the medical questions, I have verified it with my physician. I personally provided the answers on this Health Option Questionnaire and I warrant that all information disclosed herein is correct and complete. In the event of a claim, I fully understand that the Insurer will review my medical history and these answers and, if any of my answers are incorrect or incomplete, the Insurer may void my policy and my claim will be refused, regardless of whether the incorrect or incomplete answer to any question is related to the cause of my claim or would have rendered me ineligible or resulted solely in a higher applicable premium. I understand that the answers on my Health Option Questionnaire are relevant to the risk and constitute the basis of my insurance.
- b) I understand the necessity of calling belairdirect's travel claims and assistance service provider, Global Excel Management Inc., to obtain approval before seeking medical attention in case of a claim or medical emergency. The toll-free telephone number can be found on my wallet card and in my insurance policy.
- c) Medical Authorization in Case of a Claim – I understand that the insurer may investigate my claim. By signing this Application Form, 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 Belair Insurance Company Inc. and to its authorized administrator, Global Excel Management Inc., any or all information with respect to my sickness, injury, medical history, consultations, medicines or treatment and copies of all hospital or medical records for the purpose of investigating my claim.
- d) I understand that some exclusions may apply and affect my coverage. I will read my insurance policy for additional details.
- e) I understand that unless I advise belairdirect Agency Inc. to the contrary in writing, my coverage selection will remain in effect for each Policy Year thereafter. belairdirect Agency Inc. will provide me with notification of my new coverage issued before the beginning of each subsequent Policy Year, which is September 1st.
- f) I understand that coverage will terminate on August 31. A new Policy will be issued for September 1, at the Category C Health Option, under the new policy terms and conditions in effect, unless I provide written notice of termination to the Plan Administrator within 60 days from the first premium deduction for the new Policy Year. I may apply for the Category A or Category B Health Options at each new Policy Year.
- g) In addition, I authorize and direct the Insurer of Record (Insurer) and its appointed provider of Travel Assistance Services (TAS Provider) to recover claim expenses from my Provincial or Territorial Health Insurance Plan and any other insurance plans.
- h) I/We further authorize that my/our premium for this insurance, including any mid Policy Year adjustments, arrears and new Policy Year premium to be deducted from my/our chequing account based on the payment option selected.
- i) It is a condition to your new coverage coming into effect that your initial premium is paid. If we are unable to collect your first premium, no coverage will be in effect. I/We understand that my/our policy will be automatically cancelled should belairdirect Agency Inc., the Plan Administrator, receive two or more Non-Sufficient Funds (NSF) notices on my/our account.
- j) Your privacy is important to us. To read the commitment we've made to protecting your privacy, and understand how we use, collect and disclose your personal information, please visit our Privacy Promise online at belairdirect.com/en/privacy or request a copy by calling 1 866 941.5094. Our Privacy Promise may be updated from time to time. We encourage you to visit our website periodically to take notice of any changes.

Please check to confirm: (Payment Option and VOID cheque).

Selection will remain in effect unless belairdirect Agency Inc. is advised otherwise.

☐ Monthly Bank Deduction **OR** ☐ One Lump Sum Bank Deduction

☐ **I/We have attached a blank personal cheque for my/our account and marked it "VOID". I/We understand coverage will begin on the day belairdirect Agency Inc. receives my/our completed enrollment information.**

Signature of Member / Applicant

x	Date (DD/MM/YYYY)
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Signature Of Spouse (For Family or Individual Spousal Coverage)

x	Date (DD/MM/YYYY)
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Insurance products are provided by Belair Insurance Company Inc. Services are provided by belairdirect Agency Inc. Both companies share common ownership. Agents employed by belairdirect Agency Inc. only propose products underwritten by Belair Insurance Company Inc. and do not receive any commissions tied to the sale of an insurance policy.

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