

MEDICAL QUESTIONNAIRE – AGE 55 OR OVER ONLY

Applicant 1 Name (Please Print)	Date of Birth mm/dd/yy	Applicant 2 Name (Please Print)	Date of Birth mm/dd/yy
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Medical Questions determine your Eligibility. If you are uncertain of your answers to any of the medical questions, please consult your doctor before completing this questionnaire.

Step 1 – ELIGIBILITY	Applicant 1	Applicant 2
1. Have you been advised by a physician not to travel at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. IN THE LAST 5 YEARS , have you required kidney dialysis or have you been diagnosed with metastatic cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever had a bone marrow or organ transplant (excluding corneal transplant)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. IN THE LAST 2 YEARS , have you <ul style="list-style-type: none"> • been prescribed or taken Prednisone or oxygen for a lung condition; • been hospitalized (as an in-patient or seen in the emergency department) for a lung or heart condition; • had congestive heart failure, or • been prescribed or taken Lasix or Furosemide for any reason? 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. IN THE LAST 4 MONTHS , have you: <ul style="list-style-type: none"> a) been prescribed or taken 6 or more prescription medications? Do not count the following medications: hormone replacement therapy (thyroid or menopausal); drugs used for osteoporosis, traveller's diarrhea, or any form of immunization. Do not count topical medications that go in your ears or eyes or on your scalp or skin except: any form of nitroglycerine or any drug(s) for angina; or b) received treatment, other than routine follow-up, for any form of cancer (excluding basal cell and squamous cell skin cancer, and breast cancer treated only with hormonal therapy)? 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. IN THE LAST 3 YEARS , have you been diagnosed with and/or had treatment for and/or been in hospital (as an inpatient or seen in the emergency department) and/or been prescribed or taken medication for any 2 of the following (if you have had only 1 of these conditions, answer NO): <ul style="list-style-type: none"> • Heart condition; • Lung condition (medication includes any puffer(s)/inhaler(s)); • Diabetes (treated with medication and/or insulin); • Stroke/CVA (cerebrovascular accident) or mini-stroke/TIA (transient ischemic attack) including prescribed use of aspirin/Entrophen for this condition; • Peripheral vascular disease (blocked or narrowed arteries)? 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered YES to any of the above questions, you are not eligible to purchase this insurance. Contact your agent/broker or 21st Century Travel Insurance to obtain a quote for the Individual Medical Underwriting Plan. If you answered NO to all of the above questions, you are eligible to purchase this insurance. Please proceed to Step 2.

STEP 2 - READ CAREFULLY BEFORE SIGNING: I apply to the Manufacturers Life Insurance Company (Manulife Financial) for insurance under the SaveAway Travel Insurance Policy administered by 21st Century Travel Insurance Limited (21st Century). I declare that all the information I have provided on this medical questionnaire is true and complete. I have read the SaveAway Travel Insurance policy and understand the terms, conditions and exclusions (including the pre-existing condition exclusion) that apply to my coverage. I understand that if I misrepresent any material information provided in this application, Manulife Financial will void my policy and I will not be covered for any benefits under this policy. I understand that SaveAway provides a low-cost, limited coverage alternative to other travel insurance plans. It provides limited benefits with lower maximums and the savings are passed on to me through lower premiums. I understand that there is the possibility that the cost of my claim could exceed my SaveAway coverage limit and that I would be responsible for any expenses incurred that exceed that limit. I understand that 21st Century also offers products that provide higher Emergency Medical limits and broader benefits. I authorize any hospital, physician, other medical service provider or any other organization or person that has any records or knowledge of me or my health to release to World Travel Protection Inc. and/or Manulife Financial and its reinsurers and/or 21st Century, any such information for the purpose of this application and contract and any subsequent claim.

Applicant 1 Signature: _____ Applicant 2 Signature: _____ Date: _____