



# Secure VisitorLink<sup>®</sup>

## Insurance Application

(This policy must be purchased in Canada)

Broker Use Only

Broker Name

Broker#

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sample

Once you have completed and signed the Application, please mail it back to us. You can also fax it to us at 416-340-1979.

If you have any questions about this Application, please contact us at 416-340-0100 or toll-free at 1 800 216-3588.

### STEP 1 BACKGROUND INFORMATION

Have you purchased a Secure VisitorLink policy before? If so, please indicate your previous policy number: \_\_\_\_\_

Have you or any of your dependants (if family coverage was selected) ever applied for a medical insurance policy with Trent Health and been declined?  Yes

If Yes, your application may be delayed. Please give the name of the person(s) \_\_\_\_\_ and month/year declined: \_\_\_\_ / \_\_\_\_

### STEP 2 APPLICANT INFORMATION

Name of Person To Be Insured (Please Print)

First Name:

Last Name:

Country of Origin:

Arrival Date (m/d/y)

Effective Date (m/d/y)

Termination Date (m/d/y)

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Birth Date (m/d/y):

Age:

Male

Female

Language Preference:

English

French

Street:

Apt:

City:

Prov:

Postal Code:

Phone#: (     )

E-Mail Address:

Existing Insurance Coverage: Company \_\_\_\_\_ Policy #: \_\_\_\_\_

### STEP 3 SPOUSE AND DEPENDANT(S) INFORMATION

Only complete this section if selecting family coverage. If more space is required please attach a separate sheet. Your spouse, and your dependants aged 15 days but under age 19, are covered when the appropriate family premium is paid.

Spouse's Name (if also applying)		Date of Birth	Age	Sex
First Name:	Last Name:	____ / ____ / ____		<input type="checkbox"/> M <input type="checkbox"/> F
Dependent's Name (if also applying) Must be under age 19		Date of Birth	Age	Sex
First Name:	Last Name:	____ / ____ / ____		<input type="checkbox"/> M <input type="checkbox"/> F
Dependent's Name (if also applying) Must be under age 19		Date of Birth	Age	Sex
First Name:	Last Name:	____ / ____ / ____		<input type="checkbox"/> M <input type="checkbox"/> F

### STEP 4 COVERAGE SELECTION

**Select Your Coverage Option**

- Option 1 - \$ 15,000
- Option 2 - \$ 25,000
- Option 3 - \$ 50,000
- Option 4 - \$100,000
- Option 5 - \$150,000

**Choose Your Coverage Type**

- Single Coverage\* No. of days \_\_\_\_\_ x Your applicable rate from the rate card \$ \_\_\_\_\_ = 1. \$ \_\_\_\_\_
- Family Coverage\* No. of days \_\_\_\_\_ x Your applicable rate from the rate card \$ \_\_\_\_\_ x 2 = 1. \$ \_\_\_\_\_

\* Your effective date and termination date are considered as 1 day each.

For a \$0 deductible, multiply the premium on line 1 above by 5%  
(Standard deductible is \$50.00 per insured per policy period) = 2. \$ \_\_\_\_\_

**Determine Your Premium**

Add lines 1 and 2 for your premium amount  
(Minimum premium levels apply) = \$ \_\_\_\_\_

### STEP 5 PAYMENT AND DECLARATION

**Payment**

Please select your payment method from the following:

- Cash
- Cheque (Cheques are payable to Trent Health)
- Visa
- MasterCard
- Enroute
- American Express

If you are paying by credit card, please supply your card number below.

Expiry Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Cardholder if paying by credit card

\_\_\_\_\_  
Date (M/D/Y)

**Declaration**

I hereby apply to Trent Health Insurance Services Corp, and member companies of The Co-operators for insurance coverage as offered under the Trent Health Insurance program. I acknowledge I have reviewed and confirm my agreement with the Notice on Privacy and Confidentiality as indicated below. This acknowledges that information may be transmitted by facsimile (fax), e-mail, postal service, courier service or telephone, and we cannot guarantee the security or privacy of the information that is transmitted through these channels. **Notice of Privacy and Confidentiality:** The information requested on the Insurance Application is required to process the application for insurance, and in the event of a claim, is required to adjudicate your claim. To protect its confidentiality, access to this information will be restricted to those employees, mandataries, administrators or agents of Trent Health Insurance Services Corp., member companies of The Co-operators, and/or *SelectCare Risk Management Corp.* who are responsible for administration of services, underwriting, marketing; and for the processing, facilitating and investigation of claims. When necessary, this information may be shared with others such as, but not limited to, medical facilities, insurance companies, organizations, and to any other person you authorize or that is authorized by law. Call us at 1 800 379-9268 for a copy of our Privacy Statement.

The following applies to you. If family coverage is chosen, the following also applies to your spouse and dependants that are listed on this application under Step 3. This Insurance Application forms a part of the insurance contract and must be answered truthfully and completely.

I understand that this plan does not cover a medical condition which existed on or prior to the effective date of the policy, or any condition, wholly or partly, directly or indirectly, related thereto.

I am currently in good health and know of no reason why I would require medical treatment while on my insured trip. I have not been advised to seek medical treatment during my trip, nor am I travelling for the purpose of obtaining medical treatment.

I hereby authorize any medical facility, the Company, organization or person that has any records or knowledge of my health and/or that of my family members, to give to the Company, or its authorized representatives, any information regarding my health, medical history and treatment. A reproduction of this Application shall be as valid as the original.

- I understand that the policy does not cover pre-existing medical conditions; however, I will be covered for any new sickness or new injury.
- I have applied to have my pre-existing medical condition covered. I understand that in order to have my pre-existing medical condition covered, I must receive written confirmation from Trent Health Insurance Services Corp.

\_\_\_\_\_  
Applicant Signature:

\_\_\_\_\_  
Date (m/d/y):