INGLE™ INSURANCE
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VIATOR™

ROYAL & SUNALLIANCE
Forward thinking since 1710™

APPLICATION Individual Expatriate Health Insurance

For Office Use Only

*BROKER CODE: 2839 - SNO

*POLICY NUMBER

Primary Applicant Information (Please print in block letters)

(Mr, Mrs, Miss, Ms, Dr, Other)
Title

First Name(s)

Last Name

D M Y
Date of Birth

M / F
Sex

Provincial Health Card Number (optional)

Nationality on Passport(s)

Foreign Country of Residence

Occupation

Address

Mailing Address (if different from the adjacent)

Telephone Number - Residence

Telephone Number - Work

Fax Number

E-mail Address

Emergency Contact: Name and Telephone Number

Dependent Information

If there is insufficient space, please use a separate sheet and indicate that you have done so by ticking this box. ☐

	1st Dependent	2nd Dependent	3rd Dependent	4th Dependent
Last Name				
First Name(s)				
Date of Birth (D/M/Y)				
Sex	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Foreign Country of Residence				
Nationality				
Relation to Applicant				
Occupation				

Family Physician Information

This section must be filled out completely.
(If you do not have a family physician in Canada, please provide the information for the physician you visited most recently)

Name(s) of General Practitioner(s)/Family Physician(s)

Telephone Number(s)

Fax Number(s)

Address(es) of General Practitioner(s)/Family Doctor(s)

DECLARATION - A copy of this declaration shall be as valid as the original.

Part A - Pre-existing medical conditions

I/we understand that any condition (except for a minor ailment as defined in the policy) for which the insured person(s) has sought or received medical treatment, advice, follow-up visits, counseling, or has taken prescription drugs within one hundred and eighty (180) days prior to becoming insured under this policy, will not be covered until a continuous period of not less than three hundred and sixty-five (365) consecutive days has passed during which time the insured person(s) has not sought or received medical treatment, advice, follow-up visits, counseling, nor has taken prescription drugs related to such condition.

Part B - Release of Medical Information

By signing this application, 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 Royal & Sun Alliance Insurance Company of Canada and to Global Excel Management Inc. any or all information with respect to my sickness, injury, medical history, consultations, medicines or treatment and copies of all health or medical records.

Part C - Disclosure

I/we shall read the policy wording and I/we understand it to be part of the Insurance Contract issued as a result of this application. To the best of my/our knowledge and belief, the information provided in connection with this application, whether in my/our own hand or not, is true and I/we have not withheld any material facts. I/we understand that non-disclosure or misrepresentation of any material fact may entitle the insurer to void the insurance. A material fact is one likely to influence acceptance or assessment of this application by the insurer. If I am/we are in any doubt as to whether a fact is material or not, I/we have disclosed it (on a seperate sheet where necessary). This application and the information provided in connection therewith contains statements upon which the insurer will rely in deciding whether to accept this insurance and in determining the terms and conditions of such acceptance. I/we understand that the signing of this application does not bind me/us to complete, or the insurer to accept, this insurance.

X ______ Primary Applicant's Signature

D M Y ______ Date of Signature

Policy Dates (Coverage cannot be bound before ETFS receives this application).

Effective Date: D M Y

You can choose 6, 9 or 12 months coverage by ticking the appropriate box.

☐ 6 months ☐ 9 months ☐ 12 months

Type of Coverage

Refer to your rate guide for premium options.

☐ Worldwide coverage excluding the United States.

☐ Worldwide coverage including the United States.

☐ Coverage for those planning on living, working or spending more than 50% of their time, per year, in Florida.
(Florida coverage is subject to an automatic $1500 CAD deductible)

Premium Calculation

PREMIUM PER APPLICANT

Primary $ + 1st Dependant $ + 2nd Dependant $ + 3rd Dependant $ + 4th Dependant $ = **Subtotal** $

DEDUCTIBLE OPTIONS

☐ NO Deductible (Automatic)
(not available to Florida plan)

☐ $250 (Subtract 7% from premium)
(not available to Florida plan)

☐ $500 (Subtract 12% from premium)
(not available to Florida plan)

☐ $1,000 (Subtract 16% from premium)
(not available to Florida plan)

☐ $5,000 (Subtract 27% from premium)

\- $

PREMIUM PAYMENT OPTIONS & AMOUNTS
(semi-annual and quaterly payment options are only available for the 12 month coverage)

☐ Annually

☐ Semi-Annually
add 4% to premium

☐ Quarterly
add 8% to premium

\+ $

=

TOTAL PREMIUM DUE $

Method of payment

☐ Visa ☐ MasterCard ☐ Amex ☐ Diners ☐ Cheque made payable to ETFS.
You must provide ETFS with all post dated cheques for semi-annual or quartly payment.

Card Number ______ Expiry Date (M Y) ______ Signature of Cardholder ______ Date signed (D M Y)

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