

Medi-Select Advantage®

Emergency Medical Insurance Application for International Student Graduates

Your personal information is collected for the purpose of providing you with insurance services, claims analysis and payments. Call 1-800-891-0370 for a copy of the **etfs** Privacy Statement. For Privacy Information, please see www.royalsunalliance.ca, or call us at 1-800-716-4339.

Broker



20 36 APP ECA 1208 000

ELIGIBILITY

To be eligible for coverage under this plan:

- The applicant must:
 - be 60 years old or less;
 - not be eligible for a provincial or territorial health insurance plan in Canada;
 - be in good health and know of no reason to seek medical attention; and
- The applicant must have graduated within 30 days of application from a recognized Canadian institution of learning. Proof of graduation must be submitted at time of application.
- The applicant's spouse and child(ren) all of whom live together in the same residence as the applicant may be covered if the family premium is paid. (See definitions of spouse and child(ren) on the back.)

APPLICANT INFORMATION

F
 M | Last Name: _____ | First Name: _____

Country of Origin: _____ | Date of Birth (D/M/Y): ____ / ____ / ____ | Date of Arrival in Canada (D/M/Y): ____ / ____ / ____

Please enclose proof of graduation from a recognized Canadian institution of learning. | Date of Graduation (D/M/Y): ____ / ____ / ____ | School Name: _____

Address in Canada: _____ | Apt: _____

City: _____ | Province: _____ | Postal Code: _____

Phone Number: _____ | Fax Number: _____ | Email: _____

Beneficiary in case of death: _____

Spouse: Legally married Residing together for at least the last 12 months | Date of Arrival in Canada (D/M/Y): ____ / ____ / ____

| | LAST NAME | FIRST NAME | SEX |
|---------|-----------|------------|---|
| Spouse: | _____ | _____ | Date of Birth (D/M/Y) _____ F <input type="checkbox"/> M <input type="checkbox"/> |
| Child: | _____ | _____ | Date of Birth (D/M/Y) _____ F <input type="checkbox"/> M <input type="checkbox"/> |
| Child: | _____ | _____ | Date of Birth (D/M/Y) _____ F <input type="checkbox"/> M <input type="checkbox"/> |

Effective Date (D/M/Y): ____ / ____ / ____ | Termination date (D/M/Y): ____ / ____ / ____ | Number of days: _____

Daily Rate: _____ | Number of Persons: _____ | Total Premium Due (Minimum Premium \$20): _____

Cash Certified Cheque/Money Order Visa Master Card Diners American Express

Single Plan
 Family Plan

Credit Card Number: _____ | Expiry Date (M/Y): ____ / ____

Cardholder's Signature: _____

I hereby apply for coverage under this insurance policy. I am in good health and know of no reason to seek medical attention.

I understand that Royal & Sun Alliance Insurance Company of Canada and Global Excel Management Inc. may investigate my claim. 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 hospital or medical records for the purpose of investigating my claim.

Applicant's Signature: _____ | Date (D/M/Y): ____ / ____ / ____

| | | RATE SCHEDULE | | | |
|---------|--------|---------------------------|----------|-----------|-----------|
| | | Sum Insured (Daily Rates) | | | |
| Age | Plan | \$25,000 | \$50,000 | \$100,000 | \$150,000 |
| 0 - 25 | Single | \$2.94 | \$3.23 | \$3.92 | \$4.41 |
| | Family | \$7.35 | \$8.07 | \$9.80 | \$11.02 |
| 26 - 40 | Single | \$3.00 | \$3.37 | \$4.16 | \$6.36 |
| | Family | \$7.50 | \$8.42 | \$10.40 | \$15.90 |
| 41 - 60 | Single | \$3.48 | \$3.85 | \$5.45 | \$10.55 |
| | Family | \$8.70 | \$9.62 | \$13.62 | \$26.37 |

No Deductible

Minimum Premium: \$20

Age: Based on your age as of the application date.

The maximum period of coverage under this plan, including any extension(s), is 365 days.

Rates and products described are subject to change without prior notice

Apply by fax: When applying by fax, please make your premium payment by credit card. Certified cheques and money orders will be accepted by mail provided the payment is received within 10 business days of the application. No coverage will be in effect unless premium payment has been received.

DEFINITIONS for FAMILY PLAN

"Child(ren)" means an unmarried child of the principal insured or his/her spouse, who is dependent on the principal insured for support, provided that such child is between 15 days and 22 years of age on the date of application, or is 25 years of age or less provided it can be proven that the child is a full-time student, or any age if the child has a permanent physical impairment or a permanent mental deficiency on the date of application and who is dependent on you for support.

"Spouse" means the person, aged 60 or less, to whom the principal insured is legally married or with whom the principal insured has been residing for at least the last 12 months.

| FOR OFFICE USE ONLY |
|-----------------------------------|
| Effective Date (D/M/Y): / / |
| Expiry Date (D/M/Y): / / |
| Premium Paid: _____ |



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