



FORM 1 — APPLICATION AND MEDICAL QUESTIONNAIRE (To be completed by physician)

10 73 MU1 ECA 0809 000

For Broker or Sales Agent's use only:

Company Name: David Cummings Insurance Services Ltd. Contact Person: _____

Tel. Number: 604-228-8816 or 1-800-818-3188 Fax Number: 604-228-9807 E-mail: info@david-cummings.com

Part A CLIENT INFORMATION

Name: _____ Date of Birth (d/m/y): _____ Tel. Number: _____ Fax Number: _____
 Address: _____ E-mail: _____
 Travel Dates Departure (d/m/y): _____ Return (d/m/y): _____ Trip Duration: _____ days
 Exact Destination City: _____ State: _____ Country: _____

Personal information: Your personal information is collected for the purpose of providing you with insurance services, claims analysis and payments. Call 1-800-680-3837 for a copy of the **etfs** Privacy Policy. For information, please see www.rsagroup.ca, or call us at 1-800-716-4339.

Note: The masculine gender is used in this document for the sole purpose of lightening the text.

Part B MESSAGE TO THE PHYSICIAN

In taking time to fill out this questionnaire, you are helping your patient to obtain the proper emergency health insurance while he is travelling. Proper coverage will safeguard your patient's financial security.*

The answers you provide regarding your patient's health status will help us to determine his eligibility to purchase travel insurance. Although he does not qualify for our regular insurance plan, we may be able to offer the applicant a modified travel insurance program.

Please include any relevant information you feel may help us assess this patient's medical stability. If you feel your patient's condition is too unstable for him to travel this year, please discuss this matter with him and advise us in Part D - Comments. We appreciate your cooperation.

***Charges levied for the completion of this document remain the patient's responsibility.**

Part C QUESTIONNAIRE (Please type or print clearly)

List all diagnoses and medical and/or surgical conditions	Date of initial presentation	List all current medications	Date of initial prescription	Medication changes (including dosage and date) in the last 12 months	
				Medication	Dates

1. Has your patient taken **Lasix or other diuretic** in the last 5 years? yes no If yes, please provide date & dosage _____
 If so, for what condition? CHF HTN Peripheral Edema Other (please specify): _____
2. Does your patient take an **ACE-inhibitor**? yes no
 If so, for what condition? CHF HTN Other (please specify): _____
3. List any other therapy required during the past **3 years** (e.g. home oxygen, chemo, radiation therapy, etc.).
 Therapy: _____ Date or period of treatment (d/m/y): _____
 Therapy: _____ Date or period of treatment (d/m/y): _____
 Therapy: _____ Date or period of treatment (d/m/y): _____
4. List all hospitalizations during the past **3 years**.
 Date of hospitalization: _____ Diagnosis: _____
 Date of hospitalization: _____ Diagnosis: _____
 Date of hospitalization: _____ Diagnosis: _____
5. List all major tests and investigations during the past **2 years** (e.g. cardiac stress test, cardiac catheterization, scans). **Please include a copy of the test results.**
 List other recent significant tests (e.g. Hgb for anemia, creatinine for renal insufficiency, LFTs for cirrhosis, etc.).
 Test/investigation: _____ Date (d/m/y): _____ Results: _____
 Test/investigation: _____ Date (d/m/y): _____ Results: _____
 Test/investigation: _____ Date (d/m/y): _____ Results: _____
Ejection fraction (if known): % _____ Date (d/m/y): _____ **Smoking status:** yes no
6. Is the patient awaiting investigations, surgery or any other treatment?
 yes no If so, please specify the **type** and the **date** (d/m/y): _____
7. Has your patient ever undergone a **Coronary Artery Bypass Graft**? yes no Date (m/y): _____
Angioplasty? yes no Date (m/y): _____
Stenting? yes no Date (m/y): _____
8. Has the patient ever had a functional **cardiac classification** for **Angina**? yes no
 If so, what is the patient's **CURRENT class** of **Angina**? I II III IV Date of last episode (d/m/y): _____
9. Has the patient ever been diagnosed or treated for **Congestive Heart Failure**? yes no
 If so, what is the patient's **CURRENT class** of **Congestive Heart Failure**? I II III IV Date of last episode (d/m/y): _____

Part D

COMMENTS

Part E

PHYSICIAN INFORMATION

How long has the applicant been your patient (d/m/y)? _____ Are you this patient's family physician, specialist or other? _____
 Physician's name: _____ Address: _____
 Prof. No.: _____ Telephone: _____ Fax: _____

PHYSICIAN'S SIGNATURE: _____ DATE (d/m/y): _____

THIS FORM MUST BE RETURNED TO: Medical Underwriting, 73 Queen Street, Sherbrooke, Québec J1M 0C9 / Tel.: 1-800-680-3837 / Fax: 819-566-8067

