etfs Travel Insurance

# Medical Underwriting Plan

**Form 3 - Medical Update** (to be completed by the physician)

40 27 MU3 ECA 1015 000

## APPLICANT

| | |
|---|---|
| NAME: | |
| ADDRESS: | |
| TELEPHONE NUMBER: | DATE OF BIRTH (D/M/Y): |

| | | |
|---|---|---|
| **PLANNED TRIP** DEPARTURE DATE (D/M/Y): | RETURN DATE (D/M/Y): | DESTINATION: |

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

## IMPORTANT NOTICE

**Important Notice About Your Personal Information:** By submitting this application you agree that Royal & Sun Alliance Insurance Company of Canada ("we", "us") may collect, use and disclose your Personal Information (including to and from your broker, our affiliates and service providers and organizations that may have referred you to us, and professional associations of which you may be a member) for purposes of quoting a premium, policy administration, improving customer experience, administering referral arrangements, and for other lawful purposes described in our Protecting Customer Privacy document. For a copy of this document please see www.rsatravelinsurance.com.

## MESSAGE TO THE PHYSICIAN

The attached Medical Questionnaire* is being resubmitted for your review. Please specify below whether the patient's medical status has changed since the earlier completion of the questionnaire.

The answers you provide regarding your patient's health status will help us to determine his eligibility to purchase emergency travel insurance.

Please include any relevant information you feel may help us assess this patient's medical stability. Should 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 the section entitled "Comments". We appreciate your cooperation.

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

## PHYSICIAN'S ASSESSMENT

### ❑ NO CHANGE HAS occurred

I, the undersigned, certify that there have been no changes to the patient's health since the completion of the Form 1, insofar as I am aware.

I assess the patient's current medical status as follow:

### ❑ CHANGES HAVE OCCURRED

I, the undersigned, certify that the patient has experienced the following changes in his medical condition since the completion of the Form 1:

| Change in health (or medication) | Date (D/M/Y) |
|---|---|
| | |
| | |
| | |

### COMMENTS:

### PHYSICIAN INFORMATION

| | | |
|---|---|---|
| NAME: | PROF. NO.: | |
| ADDRESS: | TEL.: | FAX: |
| **SIGNATURE:** | **DATE:** | |

This form must be returned to: **RSA c/o Medical Underwriting, 1910 King Ouest, Suite 200, Sherbrooke, Quebec J1J 2E2**

**Tel.: 1-866-629-5422 Fax: 819-566-8067**