SPECIAL RISK
INSURANCE MANAGERS

Send applications to submissions@srim.ca
Toll Free 800 993 6388 | Fax 604 888 1008 | WWW.SRIM.CA

TRAVEL MEDICAL APPLICATION

Named Insured of Team, Club or Association: _____

Named Insured Mailing Address: _____

Corresponding Special Risk CGL Policy Number: _____

*****Provide an attached list of all participants and coaches to be covered including their First Name, Last Name & Date of Birth"**

COVERAGES REQUIRED

CANADIAN RESIDENT In Canada _____ Traveling Abroad _____

VISITOR TO CANADA _____

OPTIONAL PLANS Air Flight/ Common Carrier: _____ ($25,000 Limit)

Baggage, Personal Effects & Currency: _____ (Max $1,500 per person)

Trip Cancellation & Interruption Plans: $ _____ $ _____
Sum insured prior to departure — Sum Insured After Departure (Max $2000 for interruption)

Application Date/Time (YY/MM/DD): _____ Effective or Departure Date (YY/MM/DD): _____

Expiry or Return Date (YY/MM/DD): _____ Previous Special Risk Policy? (Provide Policy #): _____

Beneficiary (If applicable. Estate unless otherwise indicated.): _____ Relationship to insured: _____

DECLARATION : INSURED MUST READ AND SIGN BELOW

APPLIES TO VISITORS TO CANADA ONLY:

I acknowledge Hospital & Medial Insurance excludes any Injury or Sickness incurred within 180 days prior to the Effective Date and that a 48 Hour waiting period applies to the Sickness Benefits from the Effective Date of this Policy.

_____
ENTRY DATE TO CANADA (Y/M/D)

APPLIES TO ALL COVERAGE IN THIS POLICY:

In conjunction with the purchase of this policy, I hereby authorize release to Special Risk Insurance Managers Ltd. or its representative any information, including medical records, that is needed to process a claim filed under this policy. I am in good health and know of no reason to seek medical attention.

_____	_____	_____
AGENT'S SIGNATURE	INSURED'S SIGNATURE	DATE SIGNED (YY/MM/DD)

MEDICAL CERTIFICATE

IMPORTANT:

- This certificate is to be completed by the physician who treated the Insured with regards to this claim, or by the Insured's regular Physician.
- ANY FEE FOR THIS REPORT IS TO BE PAID BY THE CLAIMANT
- THIS FORM WILL BE RETURNED IF NOT COMPLETED AS REQUESTED

TO BE COMPLETED FOR ALL CLAIMS

Patient's Name: _____

Diagnosis/Condition Claimed for: _____ Date of First Consultation: (YY/MM/DD): _____

Was Patient Hospitalized?: _____ If Yes, name of Hospital, date of admission & discharge:

_____

Was this condition related to the use of alcohol, misuse of drugs or self inflicted injury? ☐ Yes ☐ No

Was this condition related to pregnancy? ☐ Yes ☐ No If YES, give details including expected date of delivery:

_____

Are you aware of any other physician who may have treated this patient, for this or a similar condition? ☐ Yes ☐ No If YES, please provide name & address of this physician: _____

For medically managed conditions, would the type of travel taken by the patient normally require any special medical precautions to prevent an exacerbation? ☐ Yes ☐ No

If you were treating the patient prior to traveling, was he/she fit to travel? ☐ Yes ☐ No If NO, why?

_____

In your opinion, could treatment for the above condition have been postponed until the patient's return? ☐ Yes ☐ No

In your medical opinion, would the patient have been medically fit to travel after the initial diagnosis and/ or emergency treatment?

☐ Yes ☐ No If NO, why and when would the patient have been fit to travel?

_____

TRIP CANCELLATION EXPENSES

In addition to above questions, please answer the following:

Date you were first consulted for condition that prevented travel (YY/MM/DD): _____

Date condition first diagnosed: (YY/MM/DD): _____

Has Patient ever had same or similar condition? ☐ Yes ☐ No If YES, please give date(s) of treatment: (YY/MM/DD):

_____

Date traveler made you aware of his/her travel plans (YY/MM/DD): _____

Date you advised patient/traveler that travel was inadvisable (YY/MM/DD): _____

Are you the patient's regular physician? ☐ Yes ☐ No If NO, give the name of patient's regular physician:

_____

PHYSICIAN'S CERTIFICATION & SIGNATURE

I CERTIFY that the information I have provided is correct and true to the best of my knowledge & belief.

Physicians Signature: _____ **PHYSICIAN'S STAMP:**

Date (YY/MM/DD): _____

Full Mailing Address: _____

Telephone No: _____