t.i.c travel insurance coordinators

Emergency Medical for Canadians
Travel Insurance Application Form

Full Name of Insureds (please print) FIRST	LAST	Date of Birth Y / M / D
1.		
2.		
3.		
4.		
5.		

Address in Canada:

City/Province: Postal Code:

Telephone: Departure Point: Destination:

Beneficiary ("Estate" unless otherwise indicated) For Top-ups, extensions & renewals only: Previous Policy No. ___TIC_____

Application Date: Y / M / D Time of Application: _____:_____ ❑ am ❑ pm

Effective/Departure Date: Y / M / D Number of Days Coverage:

Expiry Date: Y / M / D Number of People:

VISA ❑ MC ❑ Expiry Date:_____/_____ Auth. No.:_____

AMEX ❑ DINERS ❑ Signature_____

Credit Card Number: | | | | | | | | | | | | | | | | | | | | |

PLANS				NO. OF PERSONS	x NO. OF DAYS	x (DAILY) RATE PER PERSON	TOTAL
U.S.A. Plan							
Non-U.S.A. Plan							
Seniors' Worldwide Plan							
Group Sports Plan							
Select Annual Plan	❑ Option #1	❑ Option #2			X		
Basic Annual Plan	❑ 7 days	❑ 15 days	❑ 35 days ❑ 105 days		X		
Baggage	❑ $1,000	❑ $1,500					
Accidental Death & Disable.	❑ $25,000	❑ $100,000	❑ $250,000				
Air Flight Accident	❑ $200,000	❑ $500,000			X		
Trip Interruption	❑ $800	❑ $1,500	❑ $2,000		X		

I hereby authorize release of any information, including medical records, that is needed to process a claim filed under this policy, in conjunction with the purchase of this policy, to T.I.C. Agencies Ltd. or its representative.

The signatory confirms that every person named on this application is in good health and knows of no reason to seek medical attention. Applicants are aware that if they have any condition affecting their health, that claims relating to this condition may be excluded under this policy.

Subtotal	
Sales Tax *(where applicable)*	
Total Premium Due	

INSURED'S SIGNATURE (or person acting on behalf of Insured) DATE

SEND TO: Enhanced Health & Dental Division
Phone: 604-732-3295 or 604-264-7973
Email: travel@EnhancedHealthandDental.com
Fax: 604-264-7974

Agency Code:
3892