TiSi student

EMERGENCY INSURANCE APPLICATION

Your personal information is collected for the purpose of providing you with insurance services, claims analysis and payments.

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 admission and registration at a recognized Canadian institution of learning. | School Name: **Royal Canadian Institute of International Studies**

Address in Canada: **1992 Yonge Street Unit 200** | Apt:

City: **Toronto** | Province: **Ontario** | Postal Code: **M4S 1Z7**

Phone Number: **(416) 222-5328** | Fax Number: **(416) 222-5600** | E-mail :

DEPENDENT INFORMATION

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

	LAST NAME	FIRST NAME		SEX
Spouse:			Date of Birth (D/M/Y)	F M
Child:			Date of Birth (D/M/Y)	F M
Child:			Date of Birth (D/M/Y)	F M

INSURANCE PERIOD and PAYMENT MODE

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

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

Cash Certified Cheque/Money Order

Visa Master Card

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

Cardholder's Signature: ____________________

MEDICAL AUTHORIZATION and DECLARATION

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 Travel Underwriters and OneWorld Assist 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 examines me or who has knowledge or records of me or my health, to furnish to Travel Underwriters and to OneWorld Assist Inc. any or all information with respect to my sickness, injury, medical history, consultation, 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): ____/____/____

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2900 John Street Unit 3C
Markham, Ontario L3R 5G3
CANADA
Tel.: **(905) 415-2668**
Fax: **(905) 415-2663**
Visit us at **www.tisi.ca**

Institute / Agency : TIO 55228

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1992 Yonge Street Unit 200,
Toronto, ON M4S 1Z7
Tel : (416) 222-5328
Fax: (416) 222-5600