

EMERGENCY INSURANCE APPLICATION

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

APPLICANT INFORMATION

<input type="checkbox"/> F <input type="checkbox"/> 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: <input type="checkbox"/> Legally married <input type="checkbox"/> Residing together for at least 12 months	Date of Arrival in Canada (D/M/Y): ____ / ____ / ____												
<table border="1"> <thead> <tr> <th>LAST NAME</th> <th>FIRST NAME</th> <th>SEX</th> </tr> </thead> <tbody> <tr> <td>Spouse: _____</td> <td>_____</td> <td>Date of Birth (D/M/Y) _____ F M</td> </tr> <tr> <td>Child: _____</td> <td>_____</td> <td>Date of Birth (D/M/Y) _____ F M</td> </tr> <tr> <td>Child: _____</td> <td>_____</td> <td>Date of Birth (D/M/Y) _____ F M</td> </tr> </tbody> </table>		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
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 <input type="checkbox"/>	Certified Cheque/Money Order <input type="checkbox"/>	
Visa <input type="checkbox"/>	Master Card <input type="checkbox"/>	
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): ____ / ____ / ____

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

Royal Canadian Institute of International Studies
 1992 Yonge Street Unit 200,
 Toronto, ON M4S 1Z7
 Tel : (416) 222-5328
 Fax: (416) 222-5600