APPLICATION

Travel Edge & Travel Edge Plus Insurance

ADVICE. INSURANCE. INVESTMENTS.

For assistance in filling out this application call: **CDSPI Advisory Services Inc.**
1.800.561.9401 E-mail: insurance@cdspi.com

Please complete all pertinent questions to avoid processing delays and return to:
CDSPI, 2005 Sheppard Ave East, Suite 500, Toronto, ON M2J 5B4 Fax: 1.866.337.3389 or 416.296.8920

NOTE: Please review Membership Eligibility and Insurability requirements located below, before completing the application.

Membership Eligibility

You are eligible to renew your single or family coverage if you are:

a) a dentist qualified to practise dentistry in Canada, who is a member of the Canadian Dental Association (CDA) or a Participating Provincial or Territorial Dental Association*;
b) a full-time or graduate student in a Canadian faculty or college of dentistry;
c) a dentist under 76 years of age who is retired or receiving disability benefits and who practised in Canada and was a member of the Canadian Dental Association or a Participating Provincial or Territorial Dental Association*;
d) a dental practice staff member who is employed by an eligible dentist**;
e) an employee or retiree of a participating dental association or organization; or
f) a family member[1] of an eligible individual described in paragraph a, b, c, d or e of this section.

** As the Quebec provincial association does not participate, Quebec dentists must be members of the Canadian Dental Association to apply for coverage under this plan, and dental staff members in Quebec must work for a dentist who is a Canadian Dental Association member.*

*** Staff members may renew coverage if they change employment, if the new employer is a licensed dentist who is a member of the CDA or a participating provincial or territorial association.*

Insurability

1. Coverage is NOT AVAILABLE to any individual who:

a) has been diagnosed with a terminal[2] illness;
b) has been diagnosed with or has had an episode of congestive heart failure;
c) has Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV);
d) has Alzheimer's disease or any other type of dementia;
e) has received any type of treatment[3] for pancreatic cancer, liver cancer or any type of cancer that has metastasized;
f) has been prescribed or used home oxygen treatment in the last 12 months;
g) has had a major organ transplant (heart, kidney, liver, lung); or
h) has received kidney dialysis treatment in the last 12 months.

2. To be eligible for coverage you must:

a) be at least 15 days old and under 76 years of age; and
b) be insured for benefits under a Canadian government health insurance plan during the entire period of coverage; and
c) not reside in a nursing home and receive nursing care; and
d) not reside in a convalescent home or rehabilitation centre; and
e) not require assistance with activities of daily living.

[1] *Family Member means your legal or common-law spouse (the person who has been living with you in a conjugal relationship continuously for at least one year), widow, widower, parent, brother, sister, legal guardian, step-parent, step-brother, step-sister, aunt, uncle, niece, nephew, grandparent, grandchild, in-law, ward or child. A caregiver is also considered a family member but only when travelling with your dependent child/children.*

[2] *Terminal: a medical condition for which a physician gave a prognosis of eventual death or palliative care was received*

[3] *Treatment: a medical, therapeutic or diagnostic procedure prescribed, performed or recommended by a physician or dentist under the Dental Accident benefit, including prescribed medication, investigative testing and surgery*

INDIVIDUAL INFORMATION

Section 1 Applicant Information

1. Name (*please print*):
☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Last | First | Middle or Middle Initial

2. Mailing Address *(check one)*: ☐ Home ☐ Business

Street and Number | Suite No.

City/Town | Province | Postal Code

3.
Business Telephone | Home Telephone

Mobile Telephone | Fax

4.
E-mail address

5. Account Number, if known: ⌊ | | | | | ⌋

6. Language Preference: ☐ English ☐ French

Section 2 Party To Be Insured

Please ensure you have read and meet Eligibility and Insurability Requirements located on first page of application.

Note: Complete all questions even if the Applicant is the party to be insured.

1. Name (*please print*):
☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Last First Middle or Middle Initial

2. Birth date: Day Month Year

3. MEMBERSHIP ELIGIBILITY STATUS
Choose and complete one of the options below (*complete item A, B ,C, D, E, F, G, H, I or J*):

A. ☐ Licensed Dentist who is a member of:
☐ A participating provincial or territorial dental association
☐ CDA
Provincial/CDA License Number **(mandatory)**:

Year of Graduation: Day Month Year

Name of University or Dental Faculty:

Dental Specialty:

B. ☐ Retired or Non-Practising Dentist or Dentist receiving disability benefits

C. ☐ Dental Student
Name of University or Dental Faculty:

D. ☐ Employee of Licensed Dentist
Occupation:

Name of Employing Dentist:

Employing Dentist is a member of:
☐ A participating provincial/territorial dental association
☐ The CDA

E. ☐ Family Member of Licensed Dentist
Relationship to Dentist:

Name of Dentist:

Dentist is a member of:
☐ A participating provincial/territorial dental association
☐ The CDA
Provincial/CDA License Number **(mandatory)**:

F. ☐ Family Member of Employee
Employee's Name:

Employee's Occupation:

Name of Employing Dentist:

Employing Dentist is a member of:
☐ A participating provincial/territorial dental association
☐ The CDA

G. ☐ Employee or retiree of a participating dental association or organization
Name of Association or Organization:

H. ☐ Family member of employee or retiree of a participating dental association or organization
Name of of employee or retiree:

Relationship to employee or retiree:

Name of Association or Organization:

I. ☐ Family Member of Retired or Non-Practising Dentist or Dentist receiving disability benefits
Relationship to Dentist:

Name of Dentist:

J. ☐ Family Member of Dental Student
Relationship to Dental Student:

Name of Dental Student:

Name of University or Dental Faculty:

Section 3 Other Parties To Be Insured

Complete only if applying for Family coverage.

Please ensure each person listed below meets Eligibility and Insurability Requirements located on first page of application.

1. List below all family members (spouse or common-law partner and/or dependent children under 21, and up to age 25 if attending college or university full-time) from oldest to youngest and if applicable, your children's caregiver*. If you are selecting Top-up coverage as well, please check boxes in the last column to indicate parties travelling on the trip using that coverage, and be sure to complete section 8.

Note: If the applicant is also travelling under Top-up coverage, check here: ☐

Name (first/last)	Relationship (spouse, common-law partner, child or caregiver)	Date of Birth (day/month/year)	Full-time Student?	Mental or Physical Impairment?	Insured under a Government Health Insurance Plan?	Travelling Under Top-up Coverage?
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If more space is required for additional persons, please attach the information on a separate piece of paper.

** A caregiver can also be insured. A caregiver is a person (18 years of age or older, not related to you by blood or marriage) who is employed on a full-time basis to provide childcare in your family home. Coverage for the caregiver applies when she/he is traveling with your dependent children.*

COVERAGE APPLIED FOR

Section 4 Details

1. A. Type of Coverage

☐ Travel Edge (Medical Coverage)
☐ Travel Edge *Plus* (Medical, Flight Accident, Baggage Loss and Trip Cancellation Coverage)

B. Maximum trip length:
☐ 15 days ☐ 30 days ☐ 60 days ☐ 90 days

C. ☐ Single coverage ☐ Family coverage

2. Coverage for Travel Insurance is in effect for one year, and begins on the date your application and premium payment are received by CDSPI. However, you may specify a later effective start date for coverage.*

|_|_|_|_|_|_|_|_|
Day Month Year

*Your premium is due upon receipt of application.

Section 5 Beneficiaries – Complete ONLY if Applying for Travel Edge *Plus* Coverage

1. Below, list primary beneficiaries and contingent beneficiaries for the **Travel Edge *Plus*** Coverage for the person to be insured. In addition, if you are applying for Travel Edge *Plus* Family Coverage, list primary beneficiaries and contingent beneficiaries for your spouse.

If a beneficiary is designated as revocable, you will be able to change the beneficiary and coverage at any time without the beneficiary's consent. If the beneficiary is irrevocable, the beneficiary's written consent will be required in order to change the beneficiary, reduce coverage, cancel the policy, or make any other changes that may affect the value or ownership of the policy.

Except for a spouse beneficiary in Quebec (see below), a beneficiary designation will be revocable unless you make it irrevocable (for reasons such as satisfying the requirements of a divorce judgment, separation agreement, court order or partnership insurance agreement) by checking the box in the "irrevocable" column below.

In Quebec, the designation of a spouse as beneficiary is deemed irrevocable, unless you specify that the designation is revocable by checking the box in the Quebec column below.

If you name a minor as a beneficiary, please provide the name of the trustee appointed to receive any payment due to the minor beneficiary, following the person to be insured's death.

If you name more than one primary beneficiary, please record the percentage of the death benefit each beneficiary is to receive. If no percentage is recorded, the death benefit will be divided evenly among the surviving eligible primary beneficiaries. You may also name one or more contingent beneficiaries who will receive a death benefit only if: (a) no primary beneficiaries are alive when the benefit is payable; or (b) a court decides that the primary beneficiaries are not eligible.

Note: If sufficient space is not available, check here ☐ and complete a separate signed and dated sheet and attach to this form. Please follow the format used below, including percentage distribution if naming multiple beneficiaries.

A. Person to be insured (complete in all cases):

	Name in Full (Last, First, Middle or Middle Initial)	Relationship to Person To Be Insured	Proportion (%)	Check only if making irrevocable (see above)	In Quebec, check to make spouse beneficiary revocable
Primary Beneficiary				☐	☐
Primary Beneficiary				☐	☐
Primary Beneficiary					
Primary Beneficiary					
			Total 100%		
Contingent Beneficiary				N/A	☐
Contingent Beneficiary				N/A	☐

B. Spouse (complete only if family coverage is selected):

	Name in Full (Last, First, Middle or Middle Initial)	Relationship to Person To Be Insured	Proportion (%)	Check only if making irrevocable (see above)	In Quebec, check to make spouse beneficiary revocable
Primary Beneficiary				☐	☐
Primary Beneficiary				☐	☐
Primary Beneficiary					
Primary Beneficiary					
			Total 100%		
Contingent Beneficiary				N/A	☐
Contingent Beneficiary				N/A	☐

2. If you named a minor as a beneficiary above, please provide the name of the trustee appointed to receive any payment due to the minor beneficiary, in the event of the death of the person to be insured.

A. Beneficiary Name: _____

B. Trustee Name: _____

C. Relationship of Trustee to Person To Be Insured: _____

Note: If any children are covered under the plan, the applicant is automatically designated as the beneficiary under the child's coverage.

CALCULATION OF ANNUAL PAYMENT

Section 6 Single Coverage

1. A. Enter your premium using the Travel Edge or Travel Edge Plus tables below: $ ____

B. Enter applicable provincial tax using the tables below: + $ ____
Travel Edge Plus – SK, MB, ON, QC & NFLD only

C. Total the premium and tax and enclose payment of: = $ ____

Section 7 Family Coverage

	First Insured	Second Insured
1. A. Using the ages of the two oldest family members, enter each individual's premium using the Travel Edge or Travel Edge *Plus* tables below:	$ ____	$ ____
B. Enter applicable provincial tax using the tables below: **Travel Edge Plus – SK, MB, ON, QC & NFLD only**	+ $ ____	$ ____
C. Total the individual premium and taxes:	= $ ____	+ $ ____
D. Add the two individual amounts and enclose payment of:		= $ ____

TRAVEL EDGE				
Age	**15 Days**	**30 Days**	**60 Days**	**90 Days**
50 or under	$ 54.03	$ 64.84	$185.71	$304.57
51 – 65	$ 88.56	$106.28	$211.49	$381.94
66 – 75	$187.62	$225.14	$428.11	$746.68

TRAVEL EDGE *PLUS*				
Age	**15 Days**	**30 Days**	**60 Days**	**90 Days**
50 or under	$237.81	$285.36	$396.86	$ 515.23
51 – 65	$270.56	$324.69	$421.77	$ 587.45
66 – 75	$430.26	$516.31	$707.60	$1,009.20

TRAVEL EDGE *PLUS* APPLICABLE TAX – APPLIES TO SK, MB, ON, QC AND NL				
Saskatchewan	**15 Days**	**30 Days**	**60 Days**	**90 Days**
50 or under	$14.27	$17.12	$23.81	$30.91
51 – 65	$16.23	$19.48	$25.31	$35.25
66 – 75	$25.82	$30.98	$42.46	$60.55
Manitoba	**15 Days**	**30 Days**	**60 Days**	**90 Days**
50 or under	$16.65	$19.98	$27.78	$36.07
51 – 65	$18.94	$22.73	$29.52	$41.12
66 – 75	$30.12	$36.14	$49.53	$70.64
Ontario	**15 Days**	**30 Days**	**60 Days**	**90 Days**
50 or under	$19.02	$22.83	$31.75	$41.22
51 – 65	$21.64	$25.98	$33.74	$47.00
66 – 75	$34.42	$41.30	$56.61	$80.74
Quebec	**15 Days**	**30 Days**	**60 Days**	**90 Days**
50 or under	$21.40	$25.68	$35.72	$46.37
51 – 65	$24.35	$29.22	$37.96	$52.87
66 – 75	$38.72	$46.47	$63.68	$90.83
Newfoundland and Labrador	**15 Days**	**30 Days**	**60 Days**	**90 Days**
50 or under	$35.67	$42.80	$ 59.53	$ 77.28
51 – 65	$40.58	$48.70	$ 63.27	$ 88.12
66 – 75	$64.54	$77.45	$106.14	$151.38

Section 8 Additional Coverage Options

1. Top-up Travel Coverage:

Your travel coverage is provided for a limited number of days per trip. Top-up allows you to extend your emergency medical travel protection for a particular trip. Complete this section if you need to top-up your coverage. Please note that your trip starts on the date you leave your home province.

A. Departure Date: Day Month Year

B. Return Date: Day Month Year

C. Number of Top-up Days Required*:

D. Top-Up Daily Rate (from table below): x $

Note: For family coverage, add the daily rates for the ages of the two oldest people travelling.

E. Total Payment (C x D): = $

** The number of Top-up Days equals the number of days of your trip beyond 15, 30, 60 or 90 days, whichever is in effect under your annual plan.*

TOP-UP DAILY RATES			
Total Travel Period Days	**Age**		
	0-50	**51-65**	**66-75**
1-59	$2.39	$2.86	$ 5.16
60-89	$2.98	$3.21	$ 7.16
90-119	$4.66	$4.68	$10.29
120-149	$5.08	$5.21	$11.91
150-183	$5.49	$6.27	$12.22

2. Additional Trip Cancellation Coverage:

Trip Cancellation coverage (available only for Travel Edge *Plus*) offers a basic coverage amount of $2,000 per insured. Additional Trip Cancellation coverage can be purchased on a per-trip basis to the value of the transportation ticket to a maximum of $15,000 for a person with single coverage or $30,000 for two or more family members with family coverage (regardless of the number of people in the family). Fill out this section only if you require such additional coverage. Note: Additional coverage is available in units of $100 only.

A. This **additional** coverage is for (check all that apply):

Rate per $100	
Ages 65 and under	$5.40
Over age 65	$8.79

Additional amount requested (multiple of $100 only):

☐ Applicant $
Amount requested divided by 100:
x Rate per $100: $ (a)

☐ Spouse $
Amount requested divided by 100:
x Rate per $100: $ (b)

☐ Child(ren)
Child's Name: $
Amount requested divided by 100:
x Rate per $100: $ (c)

Child's Name: $
Amount requested divided by 100:
x Rate per $100: $ (d)

Child's Name: $
Amount requested divided by 100:
x Rate per $100: $ (e)

☐ Caregiver $
Caregiver's Name: $
Amount requested divided by 100:
x Rate per $100: $ (f)

B. Pretax amount: (a+b+c+d+e+f): $

C. Add applicable provincial tax (only applies to Saskatchewan (6%), Manitoba (7%),Ontario (8%), Quebec (9%) and Newfoundland and Labrador (15%) residents): $

D. Total amount for additional Trip Cancellation coverage (B + C): $

E. Departure Date: Day Month Year

F. Return Date: Day Month Year

DECLARATION OF INSURABILITY

Section 9 Single or Family Coverage

To be completed by all parties to be insured.

HEALTH INFORMATION

1. Using the chart below, please provide a "Yes" or "No" answer (for each person to be insured) to the following questions. If any of the following medical questions are answered "Yes", the individual(s) for whom a "Yes" answer was given is/are not eligible for this coverage.

Note: Coverage is not applicable for any *pre-existing medical condition* if that condition was not *stable* in the 90 days immediately before each *departure date*.

Have you:

A. Been diagnosed with a terminal illness?

B. Been diagnosed with or had an episode of congestive heart failure?

C. Been diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)?

D. Been diagnosed with Alzheimer's disease or any other type of dementia?

E. Received any type of treatment for pancreatic cancer, liver cancer or any other type of cancer that has metastasized?

F. Been prescribed or used home oxygen treatment in the past 12 months?

G. Had a major organ transplant (i.e. heart, kidney, liver and/or lung)?

H. Received kidney dialysis treatment in the past 12 months?

	A	B	C	D	E	F	G	H
Person to be Insured:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Spouse or partner:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Caregiver (If applicable):	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Children (Name):	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

DECLARATION AND AUTHORIZATION

Section 10 To Be Read, Signed and Dated By The Person To Be Insured/Secondary Insured*

I hereby apply to CUMIS, a member of The Co-operators group of companies for Travel Insurance offered by CDSPI. I acknowledge receipt of and confirm my agreement with the Notice on Privacy and Confidentiality set out below.

I/We declare that the information provided is complete and true to the best of my/our knowledge. I/We understand that the questionnaire and application forms part of the travel insurance agreement provided by CUMIS and administered by CDSPI. I/We further understand that any misrepresentation or non-disclosure concerning any medical condition identified in this Health Questionnaire that leads to a claim may result in non-payment of that claim. Any medical condition which I/we may now have but have not fully disclosed in Section 9 or which develops prior to my/our departure date will be subject to the pre-existing condition exclusion contained in the policy.

I reserve the right to revoke or alter the interest of any beneficiary named in this application, subject to any applicable law.

I/We hereby authorize any licensed physician, medical practitioner, hospital clinic or other medical or medically related facility, insurance company, Government Health Insurance Plan or other organization or person that has any records or knowledge of my/our health and/or that of my/our family members, to give to the Companies any information regarding my/our health, medical history and treatment. A reproduction of this Authorization shall be as valid as the original.

_____ Date: |_|_|_|_|_|_|_|_|
Signature of Person To Be Insured Day Month Year

_____ Date: |_|_|_|_|_|_|_|_|
Signature of Secondary Insured* (for Family coverage) Day Month Year

* *The oldest family member other than the applicant.*

Travel Edge Insurance and Travel Edge Plus are underwritten by CUMIS General Insurance Company, a member of The Co-operators group of companies, and administered by Allianz Global Assistance. Allianz Global Assistance is the registered business name of AZGA Service Canada Inc. and AZGA Insurance Agency Canada Ltd.

23-25 02/23

Section 11 Method of Payment

Please choose one:

☐ Cheque – Make cheque payable to CDSPI

☐ VISA or MasterCard – CDSPI will call you to obtain credit card payment details in order to activate coverage.

The best telephone number to call you at is: _____

The best time is:

- ☐ 8:30 am – 11:00 am EST
- ☐ 11:00 am – 2:00 pm EST
- ☐ 2:00 pm – 5:00 pm EST
- ☐ 5:00 pm – 7:00 pm EST

Please **do not** provide your credit card number on this form.

NOTICE ON PRIVACY AND CONFIDENTIALITY – **Must be detached, read and retained by the person to be insured**

We collect, use and disclose your personal information for purposes that include: determining eligibility, administration of services; underwriting; claims adjudication; protecting against fraud, errors or misrepresentations; and for meeting legal, regulatory or contractual requirements. Access to your personal information in our files is limited to employees, authorized agents and third-party service providers of AZGA Service Canada Inc. o/a Allianz Global Assistance and/or CUMIS General Insurance Company and other member companies of The Co-operators, CDSPI and CDSPI Advisory Services Inc., and to any other person you authorize or as authorized by law. CDSPI and CDSPI Advisory Services Inc. may also use the information collected in this application for marketing purposes and to advise you of other related products and services. These people, organizations and service providers may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You may request to review the personal information your file contains and make corrections by sending a written request to:

- **Allianz Global Assistance**: Attn: Privacy Officer, Allianz Global Assistance, PO Box 227 STN Waterloo, ON N2J 4A4.
- **CDSPI/CDSPI Advisory Services Inc**: CDSPI, Attn: The Chief Privacy Officer, 2005 Sheppard Ave East, Suite 500, Toronto, ON M2J 5B4.
  To find out more about our privacy practices, visit www.cdspi.com/privacy