TiSi student

ROYAL & SUNALLIANCE

# EMERGENCY INSURANCE APPLICATION

Your personal information is collected for the purpose of providing you with insurance services, claims analysis and payments.
Call 1-800-891-0370 for a copy of the ETFS Privacy Statement.

## 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:

Address in Canada: | Apt:

City: | Province: | Postal Code:

Phone Number: | Fax Number: | 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 Royal & Sun Alliance Insurance Company of Canada and Global Excel Management 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 examined me or who has knowledge or records of me or my health, to furnish to Royal & Sun Alliance Insurance Company of Canada and to Global Excel Management Inc.any or all information with respect to my sickness, injury, medical history, consultations, 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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**Institute / Agency :** Single

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