



Application for Coverage

Personal Information

Please print your name as you would like it to appear on your triAccess™ Identification Card.

Name (First name, middle initial, last name)	Citizenship	Date of Birth Month/Day/Year	Sex	Height	Weight
1. Applicant:		/ /			
2. Spouse:		/ /			
Dependent Children					
3. Name:		/ /			
4. Name:		/ /			
5. Name:		/ /			

Address Of Residence

Street Address: _____ City: _____ Postal Code: _____
 Province: _____ Country: _____

Mailing Address If Different From Above

Street Address: _____ City: _____ Postal Code: _____
 Province: _____ Country: _____

Your Occupation: _____ Employer Name: _____
 Date Hired: _____ Prior Employment: _____
 (if within 2 years)

Home Telephone: _____ Work Telephone: _____
 Fax Number: _____ E-mail Address: _____

If you or any family member are a U.S. citizen or if you are in the U.S. now, the following information is required:

Date of departure from U.S.: _____ Length of Residence outside U.S.: _____

Coverage Specifications - MNUI

Failure to provide complete information will delay processing.

Policy Language: "I hereby request that the Policy be drafted and provided to me in the English language."
 «Je demande que la police soit rédigée et qu'elle me soit fournie en langue anglaise.»

Platinum Deductibles (in U.S. Dollars): \$250 \$500 \$1,000 \$2,500

Requested Effective Date (must be within 30 days of signature): _____

Premium (in U.S. Dollars), from the Payment Information section on page 5: \$ _____

Medical Questionnaire - MNUI

Please answer all questions for all members of the family included in this Application. Provide details to all "Yes" answers on page 3.

	Yes	No
1. Have you ever had an application for health or life insurance voided, declined, cancelled, restricted or modified (including medical exclusion riders)?		
2. In the last 12 months, have you used tobacco in any form?		
3. In the last 12 months, have you experienced a weight change of 15 pounds or more?		
4. In the last 5 years, have you had any indication, diagnosis or treatment of alcohol or drug dependency, problem or abuse or any alcohol or drug related arrest?		
5. In the last 5 years, have you consumed alcoholic beverages in excess of 14 drinks per week?		
6. Are you pregnant or do you have an adoption pending?		
7. Do you (not including dependent children) read, write, speak and understand English? If no, what is your primary language?		
8. In the last 12 months, have you taken medication or received medical advice or treatment of any kind?		

Within the last 10 years, have you had any indication, signs, symptoms, diagnosis or treatment of any disease or disorder of: (circle applicable condition)

9. Gallbladder, pancreas or liver?		
10. Skin?		
11. Joints or spine?		
12. Kidney?		
13. Eyes, ears or nose?		
14. Mouth, throat or jaw?		

Within the last 10 years, have you had any indication, signs, symptoms, diagnosis or treatment of:

15. High blood pressure?		
16. Chest pain?		
17. Headaches?		
18. Paralysis?		
19. Arthritis?		
20. Convulsions or epilepsy?		
21. Elevated cholesterol?		
22. Sexually transmitted disease?		
23. Cancer?		
24. Diabetes or sugar in the blood or urine?		
25. Stroke?		
26. Acquired Immune Deficiency Syndrome (AIDS) or any HIV - related disease or illness?		
27. Tumor, cyst, polyp, lump or growth of any kind?		

In the last 10 years, have you:

28. Had a complicated pregnancy or delivery?		
29. Tested positive for antibodies to the HIV virus?		
30. Been hospital confined, had surgery or discussed surgery?		
31. Consulted a mental health professional?		

In the last 10 years, have you had any indication, signs, symptoms, diagnosis or treatment of any disease, disorder or abnormality of the:

32. Heart or circulatory system?		
33. Nervous system?		
34. Digestive system?		
35. Muscular or skeletal system?		
36. Respiratory system?		
37. Male or female reproductive system?		
38. Urinary system?		
39. Thyroid, breast or other glands?		
40. In the last 10 years, have you had any signs, indication, symptoms, diagnosis or treatment of any other disorder, disease, injury or adverse or abnormal test results?		

Consents, Declarations, and Authorizations - MNUU

I have personally completed this Application. I understand and agree that this application consists of the Coverage Specifications and the Medical Questionnaire. I represent that the answers and statements on this Application are true, complete and correctly recorded. I consent to the issue of a policy based on this Application. I agree that acceptance of the policy constitutes approval of the provisions of the policy and ratification of any additions or amendments.

I understand that a failure to disclose, or misrepresentation in any statement or answer in any part of the application may mean that the policy is void.

I understand that no coverage is effective until I am notified in writing by MultiNational Underwriters, Inc. I understand that if this Application is not accepted, the sole obligation of MultiNational Underwriters, Inc. is to return the premium to me.

I authorize any doctor, medical practitioner, health care practitioner, hospital, clinic, pharmacy or any other medical or medically related facility, and any government agency, insurance agency, insurance company, group policyholder or insurance or benefit administrator or any other entity, organization, institution, association or person having information, records or knowledge as to the care, advice, treatment, diagnosis or physical or mental condition of any person listed on this Application to release such information to MultiNational Underwriters, Inc. for the purposes of processing and underwriting my application, or for administering the policy or claims submitted.

I authorize MultiNational Underwriters, Inc. to share any information obtained as a result of this application, with third parties, when it is necessary for providing the product and services I have requested from MultiNational Underwriters, Inc. or other services associated with triAccess Inc., which includes evaluating insurance risk and management of claims. Third parties may include MultiNational Underwriters, Inc., reinsurers, agents, independent contractors or Best Doctors® or any of its affiliated companies.

A photostatic copy of this document is as valid as the original.

Dated at	this	day of	year
Signature of Applicant or Guardian:	Signature of Witness:		
X			
Signature of Spouse (if applying for coverage):	Signature of Witness:		
X			

Privacy Statement

At triAccess Inc. we are aware that the privacy of personal information is important to our clients. At the same time, the collection and use of personal information is fundamental to our business.

Any personal information provided with respect to this application as well as the information concerning any insurance claim will be maintained in an Individual Canadian Platinum Policy file at MultiNational Underwriters, Inc. Access to your personal information will be limited to:

- triAccess Inc. and MultiNational Underwriters, Inc. employees and representatives in the performance of their jobs;
- Those to whom you have granted access; and
- Those authorized by law

Your file will be kept at triAccess Inc. and MultiNational Underwriters, Inc. offices. You may ask to review the personal information contained in your file and request that we correct any inaccuracies. To initiate the review, please send the written request to: Access Officer at triAccess Inc., 1100, 10020-101A Avenue, Edmonton, Alberta T5J 3G2

Application for triAccess™ Coverage

I hereby apply for the triAccess™ which is comprised of the following:

- a) Canadian Platinum Policy
- b) Best Doctors® program of integrated health care services

Dated at	this	day of	year
Signature of Applicant or Guardian:	Signature of Witness:		
X			
Signature of Spouse (if applying for coverage):	Signature of Witness:		
X			

Payment Information

Applications without premium will not be processed. We will not accept cheques or money orders for Quarterly or Semi-Annual payment modes. For Quarterly or Semi-Annual payment modes we will only accept a pre-authorized credit card. Cheques, Money Orders or Credit Cards may be used for Annual payment modes. Please make all cheques payable to triAccess Inc.

Premium Calculation:

Enter the Annual Premium in U.S. dollars for each family member from the Rate Table, for the plan and deductible selected:

Applicant: \$ _____

Spouse: \$ _____

1st Child: \$ _____

2nd Child: \$ _____

3rd Child: \$ _____

Subtotal: \$ _____

Total Modal Premium Due:

\$ _____ X _____ = \$ _____
(Subtotal) (*Modal Factor)

Non-Refundable Policy Fee:
(for reinstatement purposes only) \$ _____

Total Amount Due: \$ _____

*Modal Factor: Annual=1.00 Semi-Annual=.55 Quarterly=.28
(Credit Card Only) (Credit Card Only)

Method of Payment:

All premiums are in U.S. dollars.

Cheque or Money Order (Annual payment modes only)

MasterCard

Visa

The Cheque or Money Order should be payable to triAccess Inc. All payments must be made in U.S. dollars. If paying by Credit Card, I authorize triAccess Inc. to debit my MasterCard/Visa account for the total amount due. If I have elected a Semi-Annual or Quarterly payment mode, I hereby request and authorize triAccess Inc. to debit my Credit Card account for the proper installment amount on the due dates of the installments. This authorization will remain in effect for up to 12 months or longer if the Policy is renewed, or until revoked by me in writing. Coverage purchased by Credit Card is subject to validation and acceptance by the Credit Card company.

Credit Card Number: _____

Expiration Date: _____

Name as it appears on card: _____

Billing Address: _____

Daytime Telephone: _____

Signature:

X

Associate

I certify that the foregoing answers are correct to the best of my knowledge and belief.

Associate Name:	Keith L. Hatton				
Company Name:	Hatton Financial Inc.				
Marketing Office:	PPI Edmonton				
Share:	100	%	Agent Code:		%
Date:			700148		
Signature:	X		X		X