DEFINITIONS:*

Cancer* or Carcinoma refers to any malignant tumor or abnormal new cell growth or rapid growth in any organ of the body, which has a probability of spreading to other organs through direct extension or through the lymphatic system (lymph nodes), and is usually treated by surgical resection, radiation therapy, and chemotherapy. Metastatic cancer is when the ***cancer**** has spread from the originating place to another place in the body.

Cardiovascular Condition* means any structural or functional abnormality related to the heart, blood vessels (arteries or veins) and the circulating blood.

Heart Condition* means any abnormality of any part of the heart (including the blood vessels supplying the heart, heart valves, and pericardium) that impairs the heart's normal functioning. Examples include atrial fibrillation, coronary artery disease, congestive heart failure and pacemaker.

Lung Condition* means any structural or functional abnormality involving your lungs (including COPD - Chronic Obstructive Pulmonary Disease).

Medical Check-up* means a physical exam or personal health visit or a routine visit to a physician or nurse practitioner where a medical examination is conducted or your medical history is updated, or a physical examination is done, or any symptoms were diagnosed, or any screening or relevant tests were recommended.

Medical Condition* means sickness or injury (or condition related to that sickness or injury) that required or requires ***medical treatment****.

Medical Emergency* means the unforeseen and emergent occurrence of symptoms for a sickness or injury which, unless treated immediately by a physician, may lead to death or to serious impairment of your health.

Medical Treatment* means any reasonable procedure which is medical, therapeutic or diagnostic in nature, which is medically necessary and which is prescribed by a physician. ***Medical treatment**** includes: medical advice, consultation, investigation, treatment, care, service, hospitalization, investigative testing, surgery, prescription medication (including prescribed as needed) or other treatment directly related to the sickness, injury or symptom.

Neurological Condition* means any structural or functional abnormality of the central nervous system (brain) and the peripheral nervous system (nerves).

Respiratory Condition* means any structural or functional abnormality of your airways, lungs, and chest muscles or bones supporting breathing.

Smoker* means a person who uses nicotine, including cigarettes, cigars, chewing tobacco, a nicotine patch, nicotine gum or nicotine capsules for use in vapor cigarettes.

Surgery* means any surgery that required the patient to be hospitalized overnight. Examples include knee or hip replacement, cardiovascular surgery, gastric bypass and gastric banding.

To receive a list of expanded definitions, see your **CAA Travel Consultant**.

CAA Travel Insurance, an Orion Travel Insurance product, is underwritten by Echelon Insurance. Terms and conditions apply.
®Orion Travel Insurance logo and trade name are trademarks of Echelon Insurance.
®CAA trademarks are owned by, and use is authorized by, the Canadian Automobile Association.

MB05 (07/2025)

ORION TRAVEL INSURANCE®

CAA Insurance Travel Roadside Rewards

CAA TRAVEL INSURANCE MEDICAL QUESTIONNAIRE

July 1, 2025

ELIGIBILITY:

You are not eligible for any coverage under this Policy if:

- you have been diagnosed with a terminal illness for which a physician has estimated you have less than 6 months to live;
- you have been advised by a physician against travel at this time;
- you require kidney dialysis;
- you have ever had a bone marrow or organ transplant (except skin or cornea transplant);
- you have been diagnosed with and/or received *medical treatment** for metastatic *cancer** in the last 5 years;
- you have been prescribed or taken home oxygen for a *lung condition** in the last 12 months.

INSTRUCTIONS TO THE APPLICANT:

It is important that you read these instructions carefully before completing your Medical Questionnaire.

1. Only **you**, the applicant, can complete and sign your Medical Questionnaire, not your spouse or agent. **Mistakes cannot be initialled. Please complete another Medical Questionnaire. If you have any questions on completing the Medical Questionnaire please call 204-262-6000 or 1-844-647-8723.**
2. You must answer each question truthfully. Your prior medical history will be reviewed at time of claim and if any of your answers are found to be untruthful or inaccurate you will be responsible for the first $5,000 of any claim, in addition to any Deductible applicable to your policy. You will also be required to pay the additional premium necessary based on true and accurate answers to the Medical Questionnaire, otherwise no future coverage will be provided under the Policy. If you are unsure of your ***medical condition(s)**** you must consult with your physician before completing the questionnaire.
3. Your Policy is subject to a pre-existing medical condition exclusion. Please refer to your Policy for complete details of the benefits, conditions, limitations, exclusions and definitions applicable to the insurance purchased.

PRIVACY AND CONFIDENTIALITY

The specific and detailed information requested on the Medical Questionnaire is required to process your application for travel insurance and will be used to establish and serve you as our customer. CAA Manitoba respects the privacy of its Members and Insureds in accordance to its Privacy Policy. You may contact our Privacy Officer in writing with any questions relating to the use of your personal information at 204-262-6000 or 1-844-647-8723 or visit www.caamanitoba.com/privacy_policy for details.

Name: _____

Date of Birth: _____ Policy Number: _____

DD/MM/YYYY FOR OFFICE USE ONLY

PART A – PLEASE COMPLETE			YES	NO
1.	Have you had a *medical check-up** **within the last 18 months?**		○	○
2.	**In the last 12 months** have you had more than one visit to a hospital emergency room for a *medical emergency**?		○	○
3.	**In the last 5 years** have you been a *smoker**?		○	○
4.	**In the last 12 months** have you had *surgery** (examples include: hip or knee replacement, gastric bypass or gastric banding)?		○	○
5.	**Have you EVER** required *medical treatment** or taken **ANY** prescription medications for:			
	a.	*Cardiovascular condition** (examples include: high blood pressure, high cholesterol, any heart diseases, any blood diseases, any vascular diseases)?	○	○
	b.	Diabetes?	○	○
	c.	*Cancer** (excluding basal cell and squamous cell skin cancer)?	○	○
	d.	*Neurological condition** (examples include: stroke, Parkinson's disease, Dementia, Alzheimer's)?	○	○
	e.	*Respiratory condition** (examples include: COPD or use of puffers/inhalers)?	○	○
6.	**In the last 12 months** have you had **ANY other** *medical condition** not listed above or been prescribed or are taking **ANY other** prescription medications?		○	○

If you answered **YES** to any part of Question 5 or Question 6, please continue to the appropriate section(s) in **PART B**, otherwise proceed to **PART C**.

PART B – CARDIOVASCULAR (Complete only if YES to Question 5a.)			YES	NO
7.	**Have you EVER** had a heart bypass or heart valve *surgery**?		○	○
8.	**Have you EVER** had angioplasty or a stent inserted?		○	○
9.	**In the last 12 months** have you been prescribed or taken:			
	a.	Lasix or Furosemide?	○	○
	b.	Coumadin or Warfarin?	○	○
10.	**In the last 12 months** have you required *medical treatment** or taken **ANY** prescription medications for:			
	a.	Congestive heart failure?	○	○
	b.	*Heart condition**?	○	○
	c.	High blood pressure (hypertension)?	○	○
	d.	Peripheral vascular disease (atherosclerosis or deep vein thrombosis)?	○	○
	e.	Aneurysm?	○	○

PART B – DIABETES (Complete only if YES to Question 5b.)			YES	NO
11.	**In the last 5 years** have you required *medical treatment** or taken **ANY** prescription medications for Diabetes (excluding when controlled by diet only for the last 5 years)?		○	○

PART B – CANCER (Complete only if YES to Question 5c.)			YES	NO
12.	**Have you required** *medical treatment** (including *surgery**, chemotherapy or radiation) for *cancer** in the last:			
	a.	0 to 6 months?	○	○
	b.	7 to 12 months?	○	○
	c.	13 months to 5 years?	○	○

PART B – NEUROLOGICAL (Complete only if YES to Question 5d.)			YES	NO
13.	**In the last 5 years** have you required *medical treatment** or taken **ANY** prescription medications for:			
	a.	Parkinson's Disease?	○	○
	b.	Alzheimer's disease or **ANY** other form of Dementia?	○	○
	c.	Stroke/CVA (Cerebrovascular Accident) or mini-stroke/TIA (Transient Ischemic Attack)?	○	○

PART B – RESPIRATORY (Complete only if YES to Question 5e.)			YES	NO
14.	**In the last 12 months** have you been prescribed or taken Prednisone for **ANY** *medical condition**?		○	○
15.	**In the last 5 years** have you required *medical treatment** or taken **ANY** prescription medications for a *lung condition**?		○	○

PART B – OTHER MEDICAL CONDITIONS (Complete only if YES to Question 6.)			YES	NO
16.	**In the last 12 months** have you required *medical treatment** or taken **ANY** prescription medications for:			
	a.	Acid reflux?	○	○
	b.	Diverticular disorder?	○	○
	c.	Chronic bowel disorder (including Crohn's Disease or Colitis)?	○	○
	d.	Kidney or gall bladder disorder (including stones)?	○	○
	e.	Liver or pancreas disorder?	○	○

PART C – AGREEMENT, UNDERSTANDING AND AUTHORIZATION

I confirm I have read and understood the **Eligibility**, **Instructions to Applicant** and **Definitions*** sections of this Medical Questionnaire prior to its completion. I personally completed this Medical Questionnaire and all information disclosed on it is true and accurate. I fully understand that if any of my answers are not truthful or accurate, I will be subject to the conditions described in instructions To The Applicant, item 2.

I understand Echelon Insurance (the Insurer), its agents, third party administrators or its legal representatives may investigate any claim. I authorize any hospital, physician, other medical service provider, or any other organization or person that has any records or knowledge of me and my health to release to third party administrators, the Insurer and its reinsurers any such information for the purpose of this application and contract and any subsequent claim.

Applicant's Signature_____ Date of Application _____

DD/MM/YYYY