Thank you for your continued interest in our travel insurance program.

Our goal is to provide an insurance plan for every client's needs. That is why we offer a program where medical conditions can be assessed individually by our underwriting staff.

Since it has been more than 90 days since your first application for coverage under our Medical Underwriting Plan, we have enclosed a medical questionnaire update form that your attending physician must fill out, not more than 90 days prior to your departure date.

This medical questionnaire update (Form 3) must be verified by your physician for any change in the medical information provided since the completion of Form 1. As the applicant, please complete ONLY the Applicant and Planned Trip sections at the top of the form. Your physician must complete, sign and date the Physician's Assessment section before the form is returned. Should your physician levy a charge for the completion of the questionnaire, it is your responsibility to pay that charge.

To ensure the timely review of your medical questionnaire, make sure that you return the signed form by fax at 819-566-8067 or to the following address:

RSA
c/o Medical Underwriting Department
1910 King Ouest, Suite 200
Sherbrooke, QC J1J 2E2

If you have any questions, please do not hesitate to contact one of our qualified customer service representatives who are available to answer your questions Monday to Friday from 8 a.m. to 8 p.m. and Saturday from 9 a.m. to 5 p.m. (ET).

© 2016 Royal & Sun Alliance Insurance Company of Canada. All rights reserved. ®RSA, RSA & Design and related words and logos are trademarks and the property of RSA Insurance Group plc, licensed for use by Royal & Sun Alliance Insurance Company of Canada.
This insurance product is underwritten by Royal & Sun Alliance Insurance Company of Canada.

Emergency Medical
Travel Insurance

Medical Underwriting Plan

Form 3 - Medical Update (to be completed by the physician)

10 01 MU3 ECA 0817 000

Part A CLIENT INFORMATION

Name: Date of Birth (d/m/y): / /

Address:

Tel. Number: Fax Number: E-mail:

Travel Dates Departure (d/m/y): / / Return (d/m/y): / / **Trip Duration:** days

Exact Destination City: State: Country:

IMPORTANT NOTICE

Important Notice About Your Personal Information: By submitting this application you agree that Royal & Sun Alliance Insurance Company of Canada ("we", "us") may collect, use and disclose your Personal Information (including to and from your broker, our affiliates and service providers and organizations that may have referred you to us, and professional associations of which you may be a member) for purposes of quoting a premium, policy administration, improving customer experience, administering referral arrangements, and for other lawful purposes described in our Protecting Customer Privacy document. For a copy of this document please see www.rsatravelinsurance.com.

Part B MESSAGE TO THE PHYSICIAN

The attached Medical Questionnaire* is being resubmitted for your review. Please specify below whether the patient's medical status has changed since the earlier completion of the questionnaire.

The answers you provide regarding your patient's health status will help us to determine his or her eligibility to purchase travel insurance.

Please include any additional relevant information that may help in our assessment. Do not include any results of genetic testing.

If you feel your patient should not be travelling, please discuss this matter with him or her and advise us in Part D - Comments. We appreciate your cooperation.

***IMPORTANT: Charges levied for the completion of this document remain your patient's responsibility.**

Part C PHYSICIAN'S ASSESSMENT

❑ No Change has Occurred to Patient's Health or Medication

I, the undersigned, certify that there have been no changes to the patient's health or medication since the completion of the Medical Underwriting Plan, Form 1, insofar as I am aware.

I assess the patient's current medical status as follows: _____

_____

❑ A Change has Occurred to Patient's Health or Medication

I, the undersigned, certify that the patient has experienced the following change(s) in his or her medical condition or medication since the completion of the Medical Underwriting Plan, Form 1:

List all changes in health or medication	Date (d/m/y)

Part D COMMENTS

Part E PHYSICIAN'S INFORMATION

Physician's Name:

Address:

Physician's License Number: Tel. Number: Fax Number:

PHYSICIAN'S SIGNATURE: _____ **DATE (d/m/y):** _____/_____/_____

This form must be returned to: **RSA c/o Medical Underwriting, 1910 King Ouest, Suite 200, Sherbrooke, Quebec J1J 2E2**

Tel.: 1-800-680-3837 Fax: 819-566-8067

© 2017 Royal & Sun Alliance Insurance Company of Canada. All rights reserved. ®RSA, RSA & Design and related words and logos are trademarks and the property of RSA Insurance Group plc, licensed for use by Royal & Sun Alliance Insurance Company of Canada. This insurance product is underwritten by Royal & Sun Alliance Insurance Company of Canada.