Manulife

| | | | |
|---|---|---|---|
| Policy Number: | CCM104239-1 | Coverage Type: | Single Trip |
| Purchase Date (d/m/y): | 20/10/23 | Policy Type: | Individually Underwritten |
| Effective Date (d/m/y): | 24/10/23 | Coverage Amount: | $10,000,000 |
| Expiry Date (d/m/y): | 02/12/23 | Policy Premium: | $854.84 |
| Date of Birth (d/m/y): | 01/11/54 | Tax: | $0.00 |
| Rate Category: | Clear Compare | Total Premium: | $854.84 |
| Plan Name: | Manulife Select | | |

Mrs. Sheryl Wiest

180-2400 Oakdale Way

Kamloops, British Columbia, V2B 6W7

RE: Individually Underwritten Plan

Dear : Mrs. Sheryl Wiest

Thank you for purchasing our Emergency Medical Travel Insurance underwritten by The Manufacturers Life Insurance Company. This is your confirmation which includes your personalized policy cards. Please detach and keep with your other important travel documents. Your coverage is based on the details provided by you; therefore it is important that you review the enclosed information very carefully:

**Your insurance policy.**

Please review the policy terms, conditions, limitations and exclusions that apply to your coverage as outlined in this booklet.

**Your application and medical questionnaire** (if applicable).

Please review your responses to ensure that they are accurate and true, as any misrepresentation or nondisclosure of your medical status may render your coverage null and void and will result in non-payment of any claims.

**Please contact (416) 814-5591 immediately if:**.

- any of the details do not appear accurate
- you wish to extend your coverage
- you have had a change in your medical condition or a change in medication
- you have any questions regarding your policy
- you have changes to your trip plans

In the event of an emergency you must immediately call the assistance number. Failure to do so may result in reduced benefit coverage amounts. Our emergency assistance number is 1-877-884-8189 (toll-free from the United States and Canada) or +1 (519) 251-7416 (collect to Canada where available). We are available 24 hours a day, each day of the year to offer you assistance. **Download TravelAid by ACM, a free assistance app at www.active-care.ca/travelaid.**

We appreciate your business. Travel safely!

**The top portion of this page is your receipt for income tax purposes. GST/HST Registration N° 89406 3643 RT0001**

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Detach the cards below and carry them with you at all times.

Your Travel Insurance Card

**Worldwide Coverage**

Mrs. Sheryl Wiest

180-2400 Oakdale Way

Kamloops, British Columbia, V2B 6W7

| Date: | Effective: | Expiry: | :# of days |
|---|---|---|---|
| (d/m/y) | 24/10/23 | 02/12/23 | 40 |

Policy Number: CCM104239-1

**Emergency Assistance (ACM):** 1-877-884-8189 from Canada and the US. Elsewhere, call collect +1 (519) 251-7416

ATTENTION MEDICAL PROVIDER: This is a Direct Bill Policy – please contact our assistance centre to arrange billing.

Your Travel Insurance Card

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Mrs. Sheryl Wiest

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| Date: | Effective: | Expiry: | :# of days |
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| (d/m/y) | 24/10/23 | 02/12/23 | 40 |

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# MEDICAL UNDERWRITING AGREEMENT

Mrs. Sheryl Wiest

180-2400 Oakdale Way

Kamloops, British Columbia, V2B 6W7

Dear : Mrs. Sheryl Wiest

Based on the information provided by telephone or on the online application, your existing medical conditions and your responses to the medical underwriting questions about your medical conditions, as recorded by our Customer Service Representative or on the online application, are shown on the following page(s). Please review your responses for accuracy. If there are any inaccuracies in this information, you must contact us before your departure date at 24/10/2023. Any failure to fully disclose medical conditions or changes in medical conditions or changes in medication prior to your departure will render coverage null and void.

Your pre-existing condition(s) that you have disclosed and listed on the following page(s), will be covered subject to the terms and conditions of your Emergency Medical Travel Insurance policy and only when your premium is paid in full prior to your departure.

When you applied and purchased coverage you declared your understanding that all the information you provided together with your responses to the medical questions as cited on the following page(s), must be true and complete and that if you misrepresent any material information provided or exclude any material information in this application, your policy will be voided and you will not be covered for any benefits under this policy. If your health status or medication changes between the date that you complete this application and any departure date or effective date, you must notify us at (416) 814-5591. Otherwise, any material change in your health status or medication that might lead to a change in the underwriting decision may result in an amendment of your coverage or may render coverage null and void.

When your premium has been paid in full, this Medical Underwriting Agreement becomes part of your Emergency Medical Travel insurance policy. Please take this Agreement and the policy with you when you travel.

This policy is underwritten by The Manufacturers Life Insurance Company (Manulife).

Client Name: Mrs. Sheryl Wiest

Policy Number: CCM104239-1

The following questions are the eligibility questions for this policy for which you have answered at the time of application, as follow:

| **Eligibility** | **Answers** |
|---|---|
| Are you travelling contrary to medical advice? | No |
| Are you awaiting investigative testing or treatment of an unresolved condition? | No |
| Do you require kidney dialysis? | No |
| In the past 12 months, have you used or been prescribed home oxygen for a lung condition? | No |
| Do you have a terminal illness for which a physician has estimated you have less than 6 months to live? | No |
| Please confirm that every traveler can perform ALL the regular functions of daily living? | Yes |

| **Health Assessment** | **Answers** |
|---|---|
| Have you ever had, or are you awaiting a stem cell, bone marrow, or organ transplant (except corneal transplant)? | No |
| Do you have metastatic cancer | No |
| Have you had a medical check-up in the last 18 months? | Yes |
| Have you used a tobacco product of any nature in the last two years? | No |

If any of this information is incorrect or if there are any changes prior to your departure date, you must notify us immediately. Any misrepresentation or nondisclosure of your medical status may render your coverage null and void and will result in non-payment of any claims.

| CONDITION | QUESTIONS | CUSTOMER RESPONSE |
|---|---|---|
| Benign cyst | | |
| | Is this a benign cyst of: | None of these |
| | Are you under continuing medical supervision for this condition? | No |
| Kidney stones | | |
| | Do you have any kidney stones at the moment? | No |
| | How many attacks of pain from kidney stones have you had in the last 2 years? | 0 |
| | Is the function of your kidneys impaired? | No |
| Kidney cysts | | |
| | Has this condition led to any impairment of kidney function? | No |
| | Have you had any bladder or kidney infections in the last year? | No |
| Arrhythmia | | |
| | How has your condition been treated? | Medication |
| | How many unplanned hospital visits for your irregular heartbeat have you had in the last 12 months? | 0 |
| | Do you have any further investigation or treatment planned? | No |
| | Are you on medication to thin the blood (excluding aspirin and clopidogrel)? | No |
| | Has your heart rhythm ever caused collapses, faints or blackouts? | No |

| | | |
|---|---|---|
| | Have you ever had any of the following conditions? | The following apply:<br>• **angina and/or heart attack and/or narrowed arteries of the heart**<br>The following do not apply:<br>• Heart-related breathlessness and/or ankle swelling<br>• Stroke and/or mini-stroke (tia) |
| Coronary artery disease | | |
| | Have you ever had a heart bypass, an angioplasty or a coronary stent? | No - none of these |
| | Have you ever been a smoker? | Yes - gave up more than ten years ago |
| | How many heart attacks have you had in total? | 0 |
| No heart attack or related procedures declared | | |
| | Are you waiting to see a specialist about new symptoms? or awaiting any tests, results or surgery? | No |
| | Can you always walk 200 metres on the flat with no chest pain or tightness or breathlessness? | Yes |
| | Do you ever have any chest pain or tightness or breathlessness at rest? | No |
| | Are you on medication for heart-related breathlessness or ankle swelling? | No |
| | Have you been advised to take medication for high blood pressure? | Yes |
| High blood pressure | | |
| | How many medicines does your doctor advise you to take for high blood pressure? | 1 |
| | Has your dose been increased or have you been prescribed a new tablet in the last 6 months? | No |
| | Have you ever been a smoker? | Yes - gave up more than ten years ago |
| | Have you been advised to take medication to lower your cholesterol? | Yes |
| Cholesterol levels | | |
| | Has a blood test ever at any time shown your cholesterol level to be raised? | No |
| | Have you ever been a smoker? | Yes - gave up more than ten years ago |
| | Have you been advised to take medication for high blood pressure? | Yes |
| Benign liver cysts | | |
| | How many unplanned hospital visits have you had for this condition in the last 12 months? | 0 |
| Degenerative disc disease | | |
| | In the last 5 years, has this condition affected your ability to wash, dress or feed yourself? | No |
| | Do you take pain relief daily for this condition? | No |
| | Have you had any of these treatments for your back or neck in the last 12 months? | I have had none of these in the last 12 months |
| | Are you awaiting any further scans, injections or surgery for your back or neck? | No |
| | Have you had any unplanned hospital admissions for back or neck problems in the last 2 years? | No |
| | Have you used strong painkillers at home in the last 12 months for this condition? | No |
| | Are you aged 16 or over? | Yes |
| | Please tell us your height: | 5 feet 3 inches |
| | Please tell us your weight: | 0 stones 170 pounds |

Manulife

| | | | |
|---|---|---|---|
| Policy Number: | CCM104239-2 | Coverage Type: | Single Trip Emergency Medical |
| Purchase Date (d/m/y): | 20/10/23 | Policy Type: | Individually Underwritten |
| Effective Date (d/m/y): | 24/10/23 | Coverage Amount: | $10,000,000 |
| Expiry Date (d/m/y): | 02/12/23 | Policy Premium: | $1744.51 |
| Date of Birth (d/m/y): | 17/06/55 | Tax: | $0.00 |
| Rate Category: | Clear Compare | Total Premium: | $1744.51 |
| Plan Name: | Manulife Select | | |

Mr. Kim Wiest

180-2400 Oakdale Way

Kamloops, British Columbia, V2B 6W7

RE: Individually Underwritten Plan

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We appreciate your business. Travel safely!

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**Worldwide Coverage**

Mr. Kim Wiest

180-2400 Oakdale Way

Kamloops, British Columbia, V2B 6W7

| Date: | Effective: | Expiry: | :# of days |
|---|---|---|---|
| (d/m/y) | 24/10/23 | 02/12/23 | 40 |

Policy Number: CCM104239-2

**Emergency Assistance (ACM):** 1-877-884-8189 from Canada and the US. Elsewhere, call collect +1 (519) 251-7416

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# MEDICAL UNDERWRITING AGREEMENT

Mr. Kim Wiest

180-2400 Oakdale Way

Kamloops, British Columbia, V2B 6W7

Dear : Mr. Kim Wiest

Based on the information provided by telephone or on the online application, your existing medical conditions and your responses to the medical underwriting questions about your medical conditions, as recorded by our Customer Service Representative or on the online application,, are shown on the following page(s). Please review your responses for accuracy. If there are any inaccuracies in this information, you must contact us before your departure date at 24/10/2023. Any failure to fully disclose medical conditions or changes in medical conditions or changes in medication prior to your departure will render coverage null and void.

Your pre-existing condition(s) that you have disclosed and listed on the following page(s), will be covered subject to the terms and conditions of your Emergency Medical Travel Insurance policy and only when your premium is paid in full prior to your departure.

When you applied and purchased coverage you declared your understanding that all the information you provided together with your responses to the medical questions as cited on the following page(s), must be true and complete and that if you misrepresent any material information provided or exclude any material information in this application, your policy will be voided and you will not be covered for any benefits under this policy. If your health status or medication changes between the date that you complete this application and any departure date or effective date, you must notify us at (416) 814-5591. Otherwise, any material change in your health status or medication that might lead to a change in the underwriting decision may result in an amendment of your coverage or may render coverage null and void.

When your premium has been paid in full, this Medical Underwriting Agreement becomes part of your Emergency Medical Travel insurance policy. Please take this Agreement and the policy with you when you travel.

This policy is underwritten by The Manufacturers Life Insurance Company (Manulife).

Client Name: Mr. Kim Wiest

Policy Number: CCM104239-2

The following questions are the eligibility questions for this policy for which you have answered at the time of application, as follow:

| **Eligibility** | **Answers** |
|---|---|
| Are you travelling contrary to medical advice? | No |
| Are you awaiting investigative testing or treatment of an unresolved condition? | No |
| Do you require kidney dialysis? | No |
| In the past 12 months, have you used or been prescribed home oxygen for a lung condition? | No |
| Do you have a terminal illness for which a physician has estimated you have less than 6 months to live? | No |
| Please confirm that every traveler can perform ALL the regular functions of daily living? | Yes |

| **Health Assessment** | **Answers** |
|---|---|
| Have you ever had, or are you awaiting a stem cell, bone marrow, or organ transplant (except corneal transplant)? | No |
| Do you have metastatic cancer | No |
| Have you had a medical check-up in the last 18 months? | Yes |
| Have you used a tobacco product of any nature in the last two years? | No |

If any of this information is incorrect or if there are any changes prior to your departure date, you must notify us immediately. Any misrepresentation or nondisclosure of your medical status may render your coverage null and void and will result in non-payment of any claims.

| CONDITION | QUESTIONS | CUSTOMER RESPONSE |
|---|---|---|
| Arrhythmia | | |
| | How has your condition been treated? | Cardioversion |
| | How many unplanned hospital visits for your irregular heartbeat have you had in the last 12 months? | 0 |
| | Do you have any further investigation or treatment planned? | No |
| | Are you on medication to thin the blood (excluding aspirin and clopidogrel)? | Yes |
| | Has your heart rhythm ever caused collapses, faints or blackouts? | No |
| | Have you ever had any of the following conditions? | The following apply:<br>• **no - none of these**<br>The following do not apply:<br>• Angina and/or heart attack and/or narrowed arteries of the heart<br>• Heart-related breathlessness and/or ankle swelling<br>• Stroke and/or mini-stroke (tia) |
| High cholesterol | | |
| | Has a blood test ever at any time shown your cholesterol level to be raised? | Yes |
| | Have you ever been a smoker? | Yes - still smoking |
| | Have you been advised to take medication for high blood pressure? | Yes |

| | | |
|---|---|---|
| High blood pressure | | |
| | How many medicines does your doctor advise you to take for high blood pressure? | 1 |
| | Has your dose been increased or have you been prescribed a new tablet in the last 6 months? | No |
| | Have you ever been a smoker? | Yes - still smoking |
| | Have you been advised to take medication to lower your cholesterol? | Yes |
| Diabetes | | |
| | How old is the person with this condition? | Over 16 |
| | Do you take insulin for your diabetes? | No |
| | How many unplanned hospital admissions have you had for diabetes in the last two years? | 0 |
| | Have you ever been a smoker? | Yes - still smoking |
| | Do you have (or have you had) any of the following medical conditions? | The following apply:<br>• **none of the above**<br>The following do not apply:<br>• Amputation of leg, foot or toe<br>• Angina and/or heart attack and/or narrowed arteries of the heart<br>• Impairment of kidney function<br>• Leg or foot ulcers<br>• Nerve damage<br>• Peripheral vascular disease (causes poor blood supply to legs)<br>• Retinal (eye) damage<br>• Stroke and/or tia (mini-stroke) |
| | Have you been advised to take medication for high blood pressure? | Yes |
| | Have you been advised to take medication to lower your cholesterol? | Yes |
| Cramp | | |
| | Has a physical cause for cramp been found? | Yes |
| Bulging disc | | |
| | In the last 5 years, has this condition affected your ability to wash, dress or feed yourself? | No |
| | Do you take pain relief daily for this condition? | No |
| | Have you had any of these treatments for your back or neck in the last 12 months? | Surgery |
| | Are you awaiting any further scans, injections or surgery for your back or neck? | No |
| | Have you had any unplanned hospital admissions for back or neck problems in the last 2 years? | No |
| | Have you used strong painkillers at home in the last 12 months for this condition? | No |
| | Are you aged 16 or over? | Yes |
| | Please tell us your height: | 6 feet 0 inches |
| | Please tell us your weight: | 0 stones 240 pounds |
| Copd | | |
| | How many medicines are prescribed for your breathing condition (count each inhaler as one medicine)? | 0 |
| | How many hospital admissions have you had for your breathing condition in the last year? | 0 |
| | How short of breath do you get when you are walking on the flat? | I can walk very easily without getting short of breath or the need to rest |
| | Have you ever been prescribed oxygen other than when you are in hospital? | No |
| | Have you ever been a smoker? | Yes - still smoking |
| | Have you had a chest infection or an episode of pneumonia within the last 12 months? | No |
| Sleep apnea | | |

| | | |
|---|---|---|
| | Have you been advised to use a machine to assist your breathing while you sleep? | Yes - i use it some nights |
| Pancreatitis | | |
| | What was the cause of the pancreatitis? | Other |
| | How many unplanned hospital admissions have you had for this condition in the last 2 years? | 0 |
| Gallbladder removal | | |
| | Are there any further investigations or treatment planned relating to billiary stones? | No |
| | How long ago was your last procedure to the gallbladder? | More than 3 weeks ago |
| Nerve pain | | |
| | How many medications do you take for this condition? | 0 |
| | Are you under the care of a specialist in pain management for this condition? | No |