EMERGENCY MEDICAL TRAVEL INSURANCE

MEDICAL UNDERWRITING PLAN

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

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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.

Please note, we will share the information contained in this form with your patient. In the event your patient has questions, the patient will be directed back to you for clarification.

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, 2665 King Ouest, Suite 650, Sherbrooke, Quebec J1L 2G5**

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