TravelWell® Insurance Application

Complete this form to enrol in the TravelWell Emergency Medical Basic or All Inclusive Plan, and to make changes to existing information. Send this application to your regional office for processing.

Please print clearly

Applicant Information

Policy Number	Policy Effective Date	Policy Expiry Date	TravelWell Coverage Effective Date

Last Name	First Name

Home Mailing Address

City	Province	Postal Code

Telephone Number	Date of Birth (Year / Month / Day)	
		☐ Male ☐ Female

Dependent Information

Dependants	Last Name	First Name	Male/ Female	Date of Birth Year / Month / Day
Spouse				
1st Dependant				
2nd Dependant				
3rd Dependant				
4th Dependant				

Note: *If you have more dependants, please use reverse side of application*

TravelWell Premium

☐ **Basic Plan**
- Emergency Medical Travel Insurance

☐ **All Inclusive Plan**
- Emergency Medical Travel Insurance
- Trip Cancellation/Interruption
- Baggage Loss Damage/Delay

☐ **Agency Bill**

☐ **Direct Bill**

Premium

$

TravelWell is a family rated plan, based on the age of the oldest insured member and whether TravelWell is sold in conjunction with a Principal Residence or as stand alone.

Please complete all information carefully. Incorrect or incomplete information could result in the denial or delay in paying your claims.

I have provided personal information in this document and by other means and I may in the future provide further personal information. Some of this personal information may include, but is not limited to, my credit information and claims history. I authorize my broker or insurance company to collect, use and disclose any of this personal information, subject to the law and to my broker's or insurance company's policy regarding personal information, for the purposes of communications with me, assessing my application for insurance and underwriting my policies, evaluating claims, detecting and preventing fraud, and analyzing business results. I confirm that all individuals whose personal information is contained in this document have authorized that I agree to the above on their behalf.

Insured Signature

Date

Broker

Broker Number

Branch Office

☐ **Intact Insurance Company**

☐ **Novex Insurance Company**

☐ **Trafalgar Insurance Company of Canada**