

For Assistance: Contact your Broker or call us at 1-855-337-3532
Please send your completed application form to your broker or
The Destination: Travel Group Inc.

307-211 Consumers Rd, Toronto, ON M2J 4G8 Tel / 416-499-1900 Fax / 416-499-1901

YOU MUST MEET ALL ELIGIBILITY REQUIREMENTS OUTLINED IN THE DESTINATION: INTERNATIONAL STUDENT INSURANCE POLICY.

SECTION 1 APPLICANT INFORMATION

| Last Name | First Name | Date of Birth (dd/mm/yy) |
|-----------|------------|--------------------------|
| | | |

Address in Canada

Apt

City

Prov.

Postal Code

Phone ()

Email

Beneficiary Name

Relationship

Name of Educational Institution

SECTION 2 TRIP INFORMATION AND RATE CALCULATION

Application Date (dd/mm/yy)

Date of Departure (dd/mm/yy)

Effective Date (dd/mm/yy)

Expiry Date (dd/mm/yy)

| Rate Calculation (min. premium \$20) | Rate | # of Persons | No. of Days | Total Premium Due |
|---|------|--------------|-------------|-------------------|
| Each Student/Dependent \$2.25/day or \$740/year Currency is shown in Canadian dollars. | \$ | | | |

SECTION 3 PAYMENT

Visa Mastercard Cheque / Money Order (payable to your broker or payable to: The Destination: Travel Group Inc.)

Do not share your credit card information on this form if you wish to pay by credit card.

Your broker will reach out to you directly for this confidential information.

Cardholder's Name

Cardholder's Phone Number

Signature of Cardholder

SECTION 4 DECLARATION

I understand that the Destination: International Student Insurance is subject to limitations and exclusions. I am aware that pre-existing conditions are covered only if they have been stable for 90 days prior to the effective date of my policy and I have paid the required premium.

I declare I am in good health and know of no reason to seek medical attention.

I am eligible to apply to The Manufacturers Life Insurance Company (Manulife) for insurance under Destination: International Student Insurance policy. I declare that all the information I am providing on this application is true and complete.

I understand that if I misrepresent any material information provided in this application, Manulife will void my policy and I will not be covered for any benefits under this policy.

I authorize any hospital, physician, other medical service provider or any other organization or person that has any records or knowledge of me or my health to release to the assistance and claims service provider and/or Manulife and its reinsurers any such information for the purpose of this application and contract and any subsequent claim.

Signature of Student (or person acting on behalf of Student)

Date

SECTION 5 BROKER / AGENCY INFORMATION (BROKER USE ONLY)

Broker ID

Broker Name