



Âge d'or Travel Insurance 2025-2026 Application Side 1



Bureau d'Assurance Voyage Inc.

Underwritten by Industrial Alliance Insurance and Financial Services Inc.

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1 844 500-2947

bureaudassurancevoyage.com

Name and Canadian Address

Canadian Phone #

Email

Emergency Contact Name & Phone #

Out-of-Country Address

Out-of-Country Phone #

Applicant's first and last name

Date of birth and age on Departure Date

Departure Date

The day you leave your province or territory of residence.

Effective Date The day coverage begins.

Termination Date The day coverage ends.

Number of days required

Medical Score and Plan Qualification →

To determine your Medical Score, review Table A and Table B on the reverse side and check ☒ your score.

Emergency treatment for pre-existing medical conditions will be covered if, prior to the effective date, they are stable for:

Plans Zero and 1: 90 days

Plans 2 and 3: 180 days

Plans 4 and 5: 180 days

A) Optional Multi-Trip

Check ☒ 8, 17, or 32-day and enter the premium from the rate table.

B) Daily Rate Enter your daily rate from the rate table.

C) Premium Due Multiply the number of days required by the daily rate and add the premium from Box A (if applicable).

D) Tobacco Users Add 20% if you used tobacco in the past 3 years.

E) Optional 90-Day Stability for Plans 2, 3, 4, or 5
Add 35% (Coverage limited, see brochure page 3 for details.)

F) Optional Deductibles If you do not want the \$250 USD deductible check ☒ the appropriate box and adjust the total amount due.

TOTAL AMOUNT (less any deposit or adjustment for Early Bird discount)
(Minimum \$20 per Applicant)

Applicant 1

| | | | |
|-----|-----|------|---|
| | | | Gender <input type="checkbox"/> M <input type="checkbox"/> F |
| Mth | Day | Year | Age |

| | | |
|-----|-----|------|
| Mth | Day | Year |
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| Mth | Day | Year |
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| Mth | Day | Year |
|-----|-----|------|

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| <input type="checkbox"/> 0 Points = Plan Zero |
| <input type="checkbox"/> 1 Point = Plan 1 |
| <input type="checkbox"/> 2 Points = Plan 2 |
| <input type="checkbox"/> 3 Points = Plan 3 |
| <input type="checkbox"/> 4 Points = Plan 4 |
| <input type="checkbox"/> 5 Points or more = Plan 5 |

| | |
|------------------------------------|---|
| <input type="checkbox"/> 8-day | A |
| <input type="checkbox"/> 17-day \$ | |
| <input type="checkbox"/> 32-day | |

| | |
|----|---|
| \$ | B |
|----|---|

| | |
|----|---|
| \$ | C |
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| | |
|----|---|
| \$ | D |
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|----|---|
| \$ | E |
|----|---|

| | |
|--|---|
| <input type="checkbox"/> \$0 add 15% | F |
| <input type="checkbox"/> \$99 USD add 10% | |
| <input type="checkbox"/> \$500 USD subtract 5% | |
| <input type="checkbox"/> \$1,000 USD subtract 15% | |
| <input type="checkbox"/> \$5,000 USD subtract 25% | |
| <input type="checkbox"/> \$10,000 USD subtract 35% | |

Applicant 2

| | | | |
|-----|-----|------|---|
| | | | Gender <input type="checkbox"/> M <input type="checkbox"/> F |
| Mth | Day | Year | Age |

| | | |
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| Mth | Day | Year |
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| Mth | Day | Year |
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| Mth | Day | Year |
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| <input type="checkbox"/> 0 Points = Plan Zero |
| <input type="checkbox"/> 1 Point = Plan 1 |
| <input type="checkbox"/> 2 Points = Plan 2 |
| <input type="checkbox"/> 3 Points = Plan 3 |
| <input type="checkbox"/> 4 Points = Plan 4 |
| <input type="checkbox"/> 5 Points or more = Plan 5 |

| | |
|------------------------------------|---|
| <input type="checkbox"/> 8-day | A |
| <input type="checkbox"/> 17-day \$ | |
| <input type="checkbox"/> 32-day | |

| | |
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| \$ | B |
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| \$ | D |
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| \$ | E |
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| | |
|--|---|
| <input type="checkbox"/> \$0 add 15% | F |
| <input type="checkbox"/> \$99 USD add 10% | |
| <input type="checkbox"/> \$500 USD subtract 5% | |
| <input type="checkbox"/> \$1,000 USD subtract 15% | |
| <input type="checkbox"/> \$5,000 USD subtract 25% | |
| <input type="checkbox"/> \$10,000 USD subtract 35% | |

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| \$ | + | \$ | = | \$ |
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Make cheque payable to **Bureau d'Assurance Voyage Inc.**

If paying by Visa or MasterCard, please provide card #

Check ☐ if you want your credit card charged 2 weeks prior to your departure.

Send receipt, policy and wallet cards to: ☐ Home Address **OR** ☐ Email

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| ____/____ | Expiry Date |
|-----------|-------------|

Complete both sides of this application **SCAN and EMAIL** both sides to info@bavqc.com

ANY MISREPRESENTATION OF YOUR HEALTH WILL RESULT IN A DENIED CLAIM.

Age d'or Travel Insurance Eligibility Requirements for Applicants ages 55+: You must have a valid government health insurance card for the entire duration of your trip, and answer the following:

Application Side 2

| | Applicant 1 | Applicant 2 |
|--|--|--|
| 1. Do you have a terminal illness or has your physician advised you not to travel? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Have you had coronary bypass surgery and, if so, was your most recent coronary bypass more than 12 years before your Departure Date? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. In the 3 years before your Departure Date, have you: | | |
| a. been diagnosed with or received treatment (including medication) for 3 or more conditions in Table A? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. had 2 or more heart attacks, strokes or mini-strokes (TIA)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. had 2 or more heart surgeries (including angioplasty and stent)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. been treated (including medication) for congestive heart failure? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. had kidney disease stage 3 or higher? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. had stage III or stage IV cancer or cancer that has metastasized? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. In the 12 months before your Departure Date, have you: | | |
| a. been hospitalized for any condition(s) in Table A? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. had any lung condition requiring home oxygen or prednisone tablets (except a one time usage of prednisone for up to 14 days in duration)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. had chemotherapy, radiation therapy or any surgery for cancer (excluding the removal of skin lesions other than malignant melanoma)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you answered YES to any of the questions above, you are NOT ELIGIBLE for coverage.

| Medical Score Calculation: For each condition below, enter the required number of points. | | Applicant 1 | Applicant 2 |
|--|--|---------------------|---------------------|
| Table A | Score 3 points for each condition you have been diagnosed with or received treatment (including medication) in the 3 years before your Departure Date. (Do not count Aspirin or Entrophen as treatment.) | Enter points | Enter points |
| 1. | Heart condition | | |
| 2. | Any lung condition (other than a minor infection) requiring medication (including inhalers) prescribed for use on a daily basis | | |
| 3. | High Blood Pressure requiring 3 or more medications (including a water pill) | | |
| 4. | Diabetes treated with insulin | | |
| 5. | Stroke or mini-stroke (TIA) | | |
| 6. | Blood clots | | |
| 7. | Peripheral vascular disease | | |
| 8. | Aneurysm | | |
| 9. | Alzheimer's or dementia | | |
| 10. | Parkinson's | | |
| 11. | Liver disease/disorder (includes fatty liver) or pancreatitis | | |
| 12. | Kidney stones or disease | | |
| Table B | Score 1 point for each condition you have been diagnosed with or received treatment (including medication) in the 3 years before your Departure Date. (Do not count Aspirin or Entrophen as treatment.) | Enter points | Enter points |
| 1. | Any lung condition (other than a minor infection) requiring medication (including inhalers) prescribed for use on an as needed basis (do <u>not</u> score 1 point if you scored 3 points for the lung condition in Table A) | | |
| 2. | Diabetes treated with medication other than insulin (do <u>not</u> score 1 point if you scored 3 points for diabetes treated with insulin in Table A) | | |
| 3. | High Blood Pressure requiring 2 medications (including a water pill) | | |
| 4. | Seizure(s) | | |
| 5. | Cancer (excluding the removal of skin lesions other than malignant melanoma) | | |
| 6. | Diverticulitis/Diverticulosis or Irritable Bowel Syndrome | | |
| 7. | Any gastro-intestinal disease, disorder, bleed, abscess, infection, or ulcer disease (excluding acid reflux) | | |
| 8. | Bowel obstruction or bowel surgery | | |
| 9. | Ulcerative colitis or Crohn's disease | | |
| 10. | Gallbladder disease or gallstones (unless your gallbladder has been removed) | | |
| 11. | Fainting or syncope or sought treatment for a fall | | |
| Medical Score: Your total points determine which Plan rate table to use. | | Total | |

Required: Has it been more than 3 years since your last complete medical examination (physical) with a physician?

☐ Yes ☐ No ☐ Yes ☐ No

Declaration and Authorization (You must read, sign, and date the following.)

I declare that I meet the eligibility requirements for the rate table chosen. The answers I have provided are truthful and accurate. If unsure, I have contacted my physician.

I understand that any misrepresentation or failure to disclose any material fact may void the policy.

I understand that it is my responsibility to review my policy to understand the coverage and exclusions, including the pre-existing condition exclusion.

I understand that if my health changes prior to my departure date, I must contact Bureau d'Assurance Voyage Inc. to determine how this will affect my coverage.

I authorize the disclosure of my personal and health information in the event that I have a claim.

X Applicant 1 signature

Date

X Applicant 2 signature

Date