MRM Medical Questionnaire

Name:_____ Date of Birth:_____

Address:_____ City:_____

Prov.:_____ Postal Code:_____ Phone Number:_____

Trip Information: Departure Date:_____ Return Date:_____

Insurance Option Plans:	Single Trip	8 Day Annual Plan	16 Day Annual Plan	32 Day Annual Plan	Top Up
DAYS	☐	☐	☐	☐	☐

LIST ALL MEDICAL CONDITIONS, MEDICATIONS WHEN DIAGNOSED/PRESCRIBED AND WHEN LAST CHANGED .

Medical Condition	**Yes**	**No**	**Number of Medications**	**Names of medications and Date of Last Change**
CIRCULATORY				
High Blood Pressure / Hypertension				
High Cholesterol				
Circulatory Disorder of Artery or Vein (PVD, PAD, DVT)				
Blood disorder (Anemia and other)				
Aneurysm of any type SURGICALLY repaired				
Aneurysm of any type and size			What is the size of your aneurysm in mm? _____mm	
Other circulatory disorder not listed above				
Description of Circulatory Disorder				
Hospitalized for any circulatory Disorder in the last 6 months		Date of hospitalization_____		
CARDIOVASCULAR/HEART				
Arrhythmia/Atrial Fibrillation/ Heart Murmur/ Valvular Heart disorder				
Coronary Artery Disease / Arteriosclerosis / Blocked or clogged arteries / Aneurysm surgically repaired				
Heart Attack (Myocardial infarction) Chest Pain/Angina				
Congestive Heart Failure/ water on the lungs				
Were you prescribed Lasix or Furosemide in the last 12 months for a heart condition?				
Last By-pass/Valve surgery/ angioplasty/ Stent/ Pacemaker Implant/Defibrillator within last 12 years				Date of surgical procedure _____
Last By-pass/Valve surgery/ angioplasty over 12 years ago				Date of surgical procedure _____
Other cardiac problems including congenital heart				

disorders				
Description of cardiac problems				
Hospitalized for any cardiac condition in the last 12 months		Date of hospitalization_____		
CEREBROVASCULAR/NEUROLOGICAL .				
Stroke (CVA/TIA) Cerebrovascular accident/ Transient ischemic attack (Mini Stroke)				
Other Cerebrovascular / Neurological conditions or disorders including Syncope, Alzheimer's, ALS, Parkinson's, Multiple Sclerosis, Cerebral Palsy,				
Description of Cerebrovascular or Neurological conditions				
Hospitalized for any CV/N condition in the last 12 months		Date of hospitalization_____		
RESPIRATORY/LUNG .				
COPD/Emphysema/Chronic Bronchitis				
Asthma				
Inhaler/Puffer – single unrepeated prescription for a single episode				
Current use of Home Oxygen or Prednisone				
Other lung disease of respiratory condition				
Description of other respiratory conditions				
Hospitalized for any respiratory condition in the last 12 months		Date of hospitalization_____		
GASTRO-INTESTINAL /LIVER/KIDNEY DISORDERS & ALL INTERNAL DISORDERS .				
Stomach/bowel disorder or obstruction				
Diverticular Disorder				
Gastrointestinal Bleeding				
Bleeding or perforated ulcer				
Chronic Bowel Disorder (IBS)				
Liver Disorder/Spleen/Pancreas/Gall Bladder disorder, Gall Stones not eliminated				
Cirrhosis of the Liver				
Kidney Dialysis / Renal Insufficiency				
Kidney disorder, Urinary disorder/Kidney stones not eliminated				
Other GIT or Internal condition including ulcer, hernia, reflux disorder (Gerd) or prostate disorder (not cancer)				
Description of gastrointestinal /liver/kidney conditions				
Organ transplant				
Hospitalized for any GIT or Internal condition		Date of hospitalization_____		
CANCER .				
Metastatic Cancer				
Cancer treated with radiation or chemotherapy or other BUT not including breast cancer treated with				

hormone therapy only or basal cell or squamous cell skin cancer.				
Breast Cancer treated with hormone therapy only or basil cell or squamous cell skin cancer				
DIABETES				
Diabetes with insulin				
Diabetes with medication (not insulin)				
Diabetes without medication				
Hospitalized for diabetes within the last 6 months		Date of hospitalization_____		
OTHER RISK FACTORS - MAY PROVIDE SURCHARGE, LIMITATIONS OR EXCLUSIONS				
I have Other medical/physical/musculoskeletal disorders				
Description of other medical/physical/ musculoskeletal disorder				
Date of my last medical check up was	Date: _____			
I have smoked or used tobacco products in the last				
I have taken or been prescribed home oxygen or prednisone for a lung condition in the last 12 months				
I am currently treated for anxiety				
I have received advice/treatment for a medical emergency in a hospital emergency room more than once in the last 6 months				
I have had 6 or more doctor and hospital visits in the last 12 months (exclude follow up for blood work)				
I require assistance for daily living or I am prescribed a complex care plan				
I have had one or more falls that were reported to a physician in the last 6 months				
I have been advised by a physician not to travel at this time				
Have been diagnosed as having a terminal illness, been advised by a physician not to travel or have HIV, AIDS or AIDS-related complex				
Hospitalized in the last 12 months for any other reason not mentioned above	Date _____		Reason _____	

Please list all medications prescribed in the last 6 months and note which ones are currently prescribed at this time:

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_____

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Please list all other medical complaints you have reported to a doctor in the last 2 years. In this case if you do not remember please ask your doctor what is written in your record.

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Please provide any other information that is mentioned in your medical record about your current health status.

Stability

Any change in your health status before departure date will not be covered, and your eligibility may be denied. If your health changes or does not remain stable and controlled between the date you submitted this questionnaire and the Effective date of coverage, you may not be covered if a claim occurs. You may be required to reapply for coverage and if so, please contact your broker.

Authorization

I hereby confirm that the statements and answers given herein are accurate, true and complete. I declare to have read and understood the above questions, regarding my health status. I understand that if pertinent medical information is omitted and or falsified, the Insurance Company may reduce my coverage and or render my policy null and void.

Signature_____ Date_____