WILLIS COLLEGE MEDICAL INSURANCE APPLICATION FORM

Date: _____

First Name:_____ Family Name:_____

Date Of Birth (mm/dd/yy):_____ Age:_____ Male ☐ Female ☐

Home Country:_____ Destination Country:_____

Address in Canada:_____

CAD Tel # ( )_____ CAD Email:_____

Insurance Coverage: Start Date_____End Date_____

Rate of coverage: $1.80 per day Total Premium for 1 Year (365 days) $ 657.00 CAD

How to make Payment:

We accept payment in Canadian dollars via Bank Wire Transfer. **Please include the name and student number on all payments.**

Note: Please ensure that the student name and student number is exactly the same as shown on the registration form when you wire transfer the registration fee for proper processing of the payment.

The applicant declares that:
All information I have provided in this application is true and complete. I have read and understood the terms of coverage in the documents: SGPOLICY_WILLIS_ENG and SGBS Standard_WILLIS_ENG for coverage of insurance. Including but not limited to the policy limitations and exclusions including but not limited to the emergency nature of this coverage and the pre-existing conditions exclusion that applies. I consent to the use of my personal information for the purposes of obtaining and administering insurance coverage. I authorize any hospital, physician, other medical provider or insurer to provide my complete medical record to Willis College and or Reliable Life Insurance or Travel Healthcare Insurance Solutions Inc. for the purpose of administering claims. A photocopy or facsimile transmission of this application is as valid as the original.

Signature of Applicant:_____Date:_____