

# Ingle INTERNATIONAL™

*You are not alone*

460 RICHMOND STREET WEST SUITE 100 TORONTO ON M5V 1Y1 • P 1.888.386.8888 | F 416.730.1878

## Canadian Health Insurance for International Students™

### APPLICANT INFORMATION:

School: \_\_\_\_\_  
 Last name: \_\_\_\_\_  
 First name: \_\_\_\_\_  
 Sex: \_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Country of permanent residence: \_\_\_\_\_  
 Email address: \_\_\_\_\_

### To be completed if couple or family coverage is requested:

Name:	Relationship to Insured:	Date of birth: (MM/DD/YYYY)
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____

### DATES OF COVERAGE (MM/DD/YYYY)

Effective date (start date of coverage): \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Termination date (ending date of coverage): \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Total number of days of coverage: \_\_\_\_\_

### ADDRESS IN CANADA

Address: \_\_\_\_\_  
 Telephone number: (\_\_\_\_) \_\_\_\_\_  
 Fax number: (\_\_\_\_) \_\_\_\_\_  
 City: \_\_\_\_\_ Province: \_\_\_\_\_  
 Postal code: \_\_\_\_\_

### BENEFICIARY IN CASE OF DEATH

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Country: \_\_\_\_\_  
 Relationship to insured: \_\_\_\_\_

Please enclose the following documents:

- proof of enrolment at a recognized Canadian institution of learning;
- proof of your arrival date in Canada (a photocopy of your student authorization or your passport).

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Your health insurance policy and your card will be issued when all necessary documents and full payment are received.

**SELECT TYPE OF INSURANCE PLAN:**

Please check box (✓) with rate that applies, all rates are in Canadian dollar.

- |  |             |                                     |
|--|-------------|-------------------------------------|
| <input type="checkbox"/> Platinum Student Insurance Plan   | Annual Rate | <input type="checkbox"/> \$650/year |
|  | Daily Rate  | <input type="checkbox"/> \$1.80/day |
| <input type="checkbox"/> Gold Student Insurance Plan   | Annual Rate | <input type="checkbox"/> \$550/year |
|  | Daily Rate  | <input type="checkbox"/> \$1.50/day |
| <input type="checkbox"/> Silver Student Insurance Plan<br>(All rates are individual, no family premium exists) | Annual Rate | <input type="checkbox"/> \$470/year |
|  | Daily Rate  | <input type="checkbox"/> \$1.45/day |

**PREMIUM CALCULATION**

Number of applicants (if applying for Platinum or Gold family coverage put 2.5) \_\_\_\_\_ X Student Plan Rate  
\$ \_\_\_\_\_ X Period of Coverage (number of days) \_\_\_\_\_ = Total Payment Due: \$ \_\_\_\_\_  
(\*family coverage\* is designed for parents and dependent children, for a full description please contact your agent)

**PAYMENT:**

Please fill out the credit card information or enclose a certified check or money order made payable to Ingle Insurance.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Certified Cheque | <input type="checkbox"/> VISA             | <input type="checkbox"/> MasterCard               |
| <input type="checkbox"/> Money Order      | <input type="checkbox"/> American Express | <input type="checkbox"/> Diners / Diners-En Route |

Credit card number: \_\_\_\_\_ Expiry date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Name on credit card: \_\_\_\_\_  
Credit card billing address \_\_\_\_\_  
\_\_\_\_\_

**NOTE: IF PAYING BY A METHOD OTHER THAN CREDIT CARD, YOUR POLICY WILL NOT BE MAILED UNTIL FULL PAYMENT IS RECEIVED IN OUR OFFICE.**

I understand that to be eligible for coverage I must acquire the policy within 30 days from the earliest of the date of my arrival in Canada or the date of my enrolment at a recognized Canadian institution of learning. If I am presently insured by an insurance policy administered by the assigned insurance company, I must pay the insurance premium within 30 days from the termination date of my existing policy. If I do not satisfy the eligibility conditions stated above, I understand that I will not be covered for Illness occurring during the first 30 days of insurance (unless such claim is the result of an Accident or Injury).

Signature: \_\_\_\_\_

**MEDICAL AUTHORIZATION AND DECLARATION**

I hereby authorize any insurance company, employer, hospital, medical facility, physician, pharmacist or any organization that has any records or knowledge of me or my health to release any information requested to the insurance provider or its agent with regard to the reported expenses.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_

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UNDERWRITTEN BY VARIOUS INSURANCE COMPANIES, CONTACT INGLE INSURANCE FOR INFORMATION 1-888-386-8888 (TOLL FREE)