



APPLICATION FOR EMERGENCY MEDICAL TRAVEL PLAN

1. PLEASE PRINT CLEARLY – APPLICANT INFORMATION

First Name(s)	Initials	Last Name	
Address – Street/Apt.			Sex
City/Town			<input type="checkbox"/> Male
Province		Postal Code	<input type="checkbox"/> Female
Daytime Telephone Number		Date of Birth	
Area Code	Pension Number	Day	Month Year
Provincial Health (Personal) Plan No.		E-mail Address	

2. COVERAGE SELECTION

- a) I would like to apply for coverage as indicated below for the SINGLE or FAMILY PLAN
 b) My spouse would also like to apply for coverage as indicated below for the SINGLE PLAN

Check appropriate boxes and complete the details as required:

Base Plan (unlimited trips up to 30 days duration).

OR

Supplemental Plan (includes Base Plan). Check appropriate trip option.

- 45 days 60 days 75 days 90 days 105 days
 120 days 135 days 150 days 165 days 182 days

3. COMPLETE THE FOLLOWING ONLY IF YOU HAVE ELECTED THE SUPPLEMENTAL PLAN:

Trip 1	Depart:	____ / ____ / ____	Return:	____ / ____ / ____	Destination:	____ / ____ / ____
		D M Y		D M Y	City State Country	
Trip 2	Depart:	____ / ____ / ____	Return:	____ / ____ / ____	Destination:	____ / ____ / ____
		D M Y		D M Y	City State Country	

Please provide primary destination address and telephone number if known in case we need to reach you during your trip:

Street/Apt. #									
City/Town					Province/State				
Country			Postal Code/Zip Code			Area Code and Telephone Number			

4. IF YOU HAVE SELECTED FAMILY COVERAGE, PLEASE COMPLETE THE FOLLOWING.

	FIRST NAME	LAST NAME	SEX M/F	PROVINCIAL HEALTH INSURANCE PLAN NUMBER	DATE OF BIRTH D M Y	IF CHILDREN OVER 21 INDICATE IF FULL-TIME STUDENT OR HANDICAPPED
SPOUSE					/ /	
DEPENDENT						
DEPENDENT						
DEPENDENT						

IMPORTANT – YOU MUST COMPLETE AND SIGN SECTION 5 ON THE REVERSE FOR COVERAGE TO BE IN FORCE

5. I HEREBY CERTIFY THAT I AM A MEMBER IN GOOD STANDING OF RTAM AND MY ELIGIBILITY CEASES UPON TERMINATION OF MY RTAM MEMBERSHIP.

I authorize and direct the Insurer of Record and its appointed provider of Travel Assistance Services to recover claim expenses from my Provincial Health Insurance Plan and any other insurance plans (if applicable).

I further authorize that my premium for this insurance, including any mid policy year adjustments, arrears and renewals, be deducted in monthly amounts due on or after this date of application. I understand that my policy will be automatically cancelled should Johnson Inc. receive two or more Non Sufficient Funds (NSF) notices on my account. I understand coverage will begin on the day Johnson Inc. receives my completed enrollment information. I also understand that unless I advise Johnson Inc. in writing to the contrary, the coverage I have selected will remain in effect for each policy year thereafter. Johnson Inc. will provide me with notification of my renewal before the beginning of each subsequent policy year, which is September 1.

Check Appropriate Box:

- I am an RTAM Member.** I am in receipt of a TRAF Pension (No. _____ found on the top right corner of any letter from TRAF) and authorize the Teachers' Retirement Allowances Fund (TRAF) to deduct from my pension payment the amount of my insurance premium (including mid-term adjustments and arrears) payable to **Johnson Inc.**

- I am an RTAM Member.** I am not in receipt of a TRAF pension. I have enclosed a **sample cheque marked "VOID"**. I authorize Johnson Inc., the plan administrator, to make monthly deductions (including mid-term adjustments and arrears) from the bank, trust company or credit union account shown on the cheque.

Signature of Applicant	Date
Signature of Spouse (if family or single spousal coverage selected)	Date

Privacy Statement

The Federal and Provincial Governments recently enacted legislation to protect the personal information of Canadians. RTAM has devised this statement to inform you of the steps taken to comply with the legislation. Maritime Life, Johnson Inc., or World Access may use your personal information for the following purpose:

They may collect personal and other information about you to provide your requested coverage and services to process claims. The primary sources of information are you, RTAM, and your medical advisors. To administer and otherwise provide you the coverage and services requested, World Access may collect information from individuals, groups, or companies from whom collection is necessary.

Please return the completed application form to Johnson Inc. at the address below. All inquiries about the application, policies, authorization for premium deductions or any written notice of change or cancellation are also to be directed to Johnson Inc.

Johnson Inc.
 Plan Benefits Service
 #301 West Chambers Bldg.
 12220 Stony Plain Road
 Edmonton, Alberta T5N 3Y4
Toll-free 1-877-989-2600

