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PERSONAL HEALTH COVERAGE
Application

A. Applicant Information

Address	City	Province	Postal Code

Phone *(where applicant can be reached)* ( )	Email	❑ *Yes, I would like to receive email about special offers, promotions and opportunities to provide feedback about GMS products and services.*

Persons to be Insured† *(collectively referred to as Applicants)*	**First Name**	**Last Name**	**Provincial Health Care Coverage in Place?**	**Sex** *(M/F)*	**Date of Birth** *(DD/MM/YYYY)*	**Student***
1. Applicant			❑ Yes ❑ No			N/A
2. Spouse/ Common Law			❑ Yes ❑ No			N/A
3. Dependant			❑ Yes ❑ No			❑
4. Dependant			❑ Yes ❑ No			❑
5. Dependant			❑ Yes ❑ No			❑
6. Dependant			❑ Yes ❑ No			❑

†*Families with more than six people must complete and attach an additional application form.*
**Students between the age of 21 and 24 must be attending a full-time educational training program within Canada when applying. Verification of over-age dependants will be requested annually. For permanently disabled dependants over the age of 20, medical verification will be requested.*

B. Coverage Selection

Select Coverage Type	Select Plan Type	Additional Coverage Options *(only available when purchased with a Plan)*		
❑ Single	❑ OmniPlan	❑ Basic Prescription Drug	❑ Dental Care	❑ 15-Day Annual Travel
❑ Couple	❑ ExtendaPlan	❑ Enhanced Prescription Drug	❑ Hospital Cash	❑ 30-Day Annual Travel
❑ Family	❑ BasicPlan			❑ 48-Day Annual Travel

I would like my coverage to be effective on: *(DD/MM/YYYY)*

C. Other Insurance Coverage *(only include personal or group plans that will continue to be in effect at the same time as the GMS health plan)*

Do any listed Applicants have additional coverage with another insurer? ❑ Yes ❑ No *If "Yes", please complete the section below.*

Insurance Company Name	**Name of Insured Person**	**Policy/Certificate #**	**Persons Covered under Plan**	**Coverage** *(check all that apply)* ❑ *Personal Plan* ❑ *Group Plan*
			❑ Applicant ❑ Spouse ❑ Dependant	❑ Health ❑ Drug ❑ Vision ❑ Dental ❑ Travel
			❑ Applicant ❑ Spouse ❑ Dependant	❑ Health ❑ Drug ❑ Vision ❑ Dental ❑ Travel

D. Health Plan Conversion *(if this plan is being used to replace an existing GMS plan or another insurer's health plan please complete the following)*

Are any listed Applicants converting from another GMS plan? ❑ Yes ❑ No *If "Yes", please indicate the expiry/end date of your previous coverage in the box to the right.*	Expiry/End Date of Previous Coverage *(DD/MM/YYYY)*

Are any listed Applicants converting from another insurer's health benefit plan that offers a similar drug, dental and health benefits?
❑ Yes ❑ No *If "Yes" please provide details below.*

Insurer	Plan Number	End Date of Coverage *(DD/MM/YYYY)*

E. Simplified Medical Information *(applicable if only purchasing a BasicPlan)*

Instructions

Proceed to Section G if you are 59 years of age or younger and are purchasing a BasicPlan or BasicPlan with Dental Care.

If you are:

- purchasing a BasicPlan with the Basic or Enhanced Prescription Drug, and/or Hospital Cash additional coverage option(s); or
- 60 years of age and over and purchasing a BasicPlan or a BasicPlan with Dental Care
- purchasing an OmniPlan or ExtendaPlan, provided optional Annual Travel is not selected.

please answer the following medical question.

In the last two years, have you, your spouse or any of your dependants:

- received therapeutic services from a health practitioner (chiropractor, physiotherapist, massage therapist, psychologist, podiatrist or acupuncturist);
- consulted a medical professional for any reason other than a regularly scheduled wellness exam or to address a minor ailment such as a cold or flu or for vaccinations;
- used one or more prescription drug(s) on a regular basis to treat a diagnosed medical condition, or control undiagnosed symptoms (does not include oral birth control); or
- been diagnosed with a chronic medical condition or been advised to seek further diagnostic testing, surgery or in-hospital care?

❑ Yes, one or more of the above statements apply to me, my spouse and/or my dependants. Please proceed to Section F.

❑ No, none of the above statements apply to me, my spouse and/or my dependants. Please proceed to Section G to complete your purchase.

F. Detailed Medical Information

Instructions

You are required to complete this section if you:

- answered "Yes" in Section E (Simplified Medical Information); or
- are purchasing an OmniPlan® or ExtendaPlan® or BasicPlan with optional Annual Travel coverage.

In the past two years, have any Applicants consulted a physician or specialist about, suffered from, been diagnosed with, received treatment or taken prescription drugs for any of the following? If "Yes", please specify details in space below.

1. Heart Attack / Congestive Heart Failure / Angina / Irregular Heartbeat / Other Heart Conditions ❑ Yes ❑ No

Applicant's First Name	Specify Condition	Date Diagnosed	Treatment & Prescribed Medication

2. Stroke / Transient Ischemic Attack (TIA) / Blood Clots ❑ Yes ❑ No

Applicant's First Name	Specify Condition	Date Diagnosed	Treatment & Prescribed Medication

3. Aneurysm / Peripheral Vascular Disease ❑ Yes ❑ No

Applicant's First Name	Specify Condition	Date Diagnosed	Treatment & Prescribed Medication

4. Home Oxygen Therapy ❑ Yes ❑ No

Applicant's First Name	Specify Condition	Date Diagnosed	Treatment & Prescribed Medication

5. Diabetes ❑ Yes ❑ No

Applicant's First Name	Specify Condition	Date Diagnosed	Treatment & Prescribed Medication

6. Liver Disease / Kidney Disease and/or Failure / Bladder Disorder ❑ Yes ❑ No

Applicant's First Name	Specify Condition	Date Diagnosed	Treatment & Prescribed Medication

Medical questions continue on next page

F. Detailed Medical Information *Continued*

7. Gastrointestinal Disorder / Crohn's / Colitis / Irritable Bowel Syndrome (IBS) ❑ Yes ❑ No

Applicant's First Name	Specify Condition	Date Diagnosed	Treatment & Prescribed Medication

8. Cancer / Tumour / Any Terminal Disease ❑ Yes ❑ No

Applicant's First Name	Specify Condition	Date Diagnosed	Treatment & Prescribed Medication

9. AIDS / HIV ❑ Yes ❑ No

Applicant's First Name	Specify Condition	Date Diagnosed	Treatment & Prescribed Medication

10. Arthritis / Rheumatism / Musculoskeletal Disorder ❑ Yes ❑ No

Applicant's First Name	Specify Condition	Date Diagnosed	Treatment & Prescribed Medication

11. Any other disease / disorder / condition or physical impairment? ❑ Yes ❑ No

Applicant's First Name	Specify Condition	Date Diagnosed	Treatment & Prescribed Medication

12. Two or more episodes of fainting or falling (Syncope)? ❑ Yes ❑ No

Applicant's First Name	Specify Condition	Date Diagnosed	Treatment & Prescribed Medication

13. In the past two years, has any Applicant consulted, received advice or treatment or been advised to seek treatment from a chiropractor, physiotherapist, massage therapist, psychologist, podiatrist or acupuncturist? ❑ Yes ❑ No

Applicant's First Name	Type of Practitioner	Medical Condition	Date Diagnosed	Number of visits in last 2 years

14. Are any Applicants currently on a waiting list, scheduled for or otherwise awaiting hospitalization or surgery? ❑ Yes ❑ No

Applicant's First Name	Type of Treatment	Medical Condition	Expected Date of Treatment

15. Has a doctor advised any Applicants to take any tests or exams that have yet to be completed? ❑ Yes ❑ No

Applicant's First Name	Type of Test/Exam	Medical Condition if known	Expected Date of Treatment

16. In the past six months, have any Applicants taken any prescription drug(s) or have a prescription for which refills are currently authorized? (Please attach a separate sheet of paper for additional prescriptions.) ❑ Yes ❑ No

Applicant's First Name	Prescription Name, Strength & Dosage	Medical Condition	Length of Time Used	Refills Authorized
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No

G. Determine Rate Calculation *(view the rate schedule for your province at www.gms.ca)*

Health Plan Type Monthly Premium *(OmniPlan®, ExtendaPlan® or BasicPlan)*	Additional Coverage Options					
	Basic Prescription Drug Monthly Premium	Enhanced Prescription Drug Monthly Premium	Dental Care Monthly Premium	Hospital Cash Monthly Premium	Annual Travel	TOTAL
$	+ $	+ $	+ $	+ $	+ $	=

When determining your monthly rate

- Depending on your province of residence the premium charged may be subject to tax;
- Family means three or more;
- a 30% surcharge will apply to all plans with more than six individuals to be insured;
- for Couple or Family, the oldest person on the application determines the rate; and
- based on your medical history, you may be assessed a premium adjustment, excluded for certain benefits, or declined coverage.

GMS must approve your application and receive the appropriate premium before coverage becomes effective. Waiting periods apply to some benefits. Coverage will be governed by the terms and conditions described in the policy available at www.gms.ca. A copy of the policy will be sent to you upon acceptance of your application by GMS. If an adjustment has been made to your policy and you are not fully satisfied, you will have 30 days from confirmation to obtain a full refund.

H. Method of Payment *(select annual or monthly payment option)*

❑ Annual Payment Option

Annual Premium:

$ ❑ Cash ❑ Cheque ❑ Visa ❑ MasterCard

Credit Card Number	Expiry Date *(MM/YY)*	Signature of Cardholder
		X

❑ Monthly payment plan through Pre-Authorized Debit (PAD)

Your first month's payment must be made separately by one of the options below. Your bank account will **not** be debited for your first month's payment.
How would you like to make your first month's payment? ❑ Cheque ❑ Cash ❑ Visa ❑ MasterCard *(Please do not send cash in the mail)*

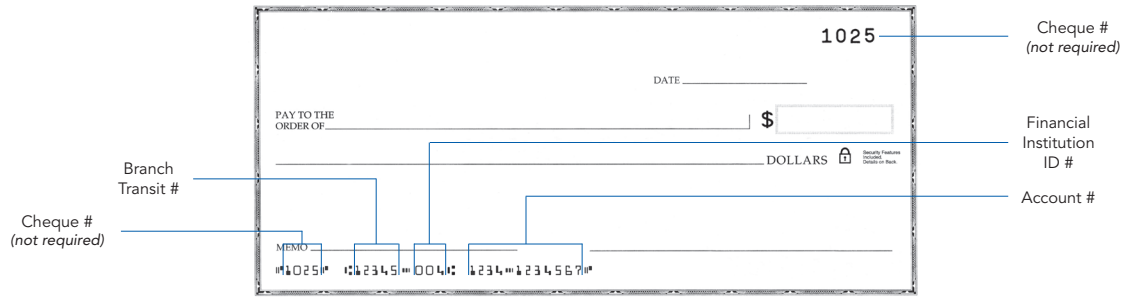
Credit Card Number	Expiry Date *(MM/YY)*	Signature of Cardholder
		X

Account Information (*please complete banking information below or include a void cheque*)

First Name of Account Holder *(if different than applicant)*	Last Name of Account Holder *(if different than applicant)*	
Name of Financial Institution	Address	
City	Province	Postal Code

Type of Account *(Only Canadian Accounts are accepted)* ❑ Savings ❑ Chequing

Monthly Premium Amount: $		Monthly Withdrawal Date: ❑ 1st of the month ❑ 15th of the month
Branch Transit Number	Financial Institution ID Number	Account Number



Pre-Authorized Debit (PAD) Agreement

I/We ('I") authorize Group Medical Services (GMS), and the financial institution being designated to begin deductions as per my/our ("my") instruction for monthly regular recurring payments, and/or one-time payments from time to time, for payment of all charges arising under my GMS account(s).

This Pre-Authorized Debit (PAD) agreement may be cancelled at any time provided notice is received in writing, at the address provided at least 10 business days before the next withdrawal is scheduled to be processed. Please contact our office or visit our website to obtain a cancellation form.

I have certain recourse rights if any withdrawal does not comply with this agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

The following terms and conditions apply to the processing of a PAD withdrawal.

- For health plans, an administration fee of $1 per month is applied to the amount owed when payment is made using PAD and will be applied to your monthly withdrawal.
- Non-Sufficient Fund (NSF) withdrawals will be handled in accordance with GMS' standard NSF policy and in accordance with the rules laid out by The Canadian Payments Association (CPA).
- Information on the administration fees and GMS' standard NSF policy can be found at gms.ca
- Withdrawal payments will continue until such time as written notice to the contrary is given, in accordance to the right of termination outlined in this PAD Agreement. Any outstanding premium must be paid in full at such time to ensure continued coverage of the product/service payment was being applied to.
- Where a one-time payment is to be processed, funds will be withdrawn on my regular withdrawal date in the month following the service delivered.
- Any change to the information provided under this PAD Agreement or to the product or service for which this PAD Agreement is attached, will require that a new PAD Agreement be completed, signed and submitted to GMS Head Office along with a void cheque. We require receipt of this new PAD Agreement at least 10 business days before the next debit is scheduled to process.

I agree to and understand the terms and conditions set forth and ask that funds begin to be withdrawn from my account as indicated.

Signature of Authorized Account Holders

X

I. Applicant Declaration

I/We ("I") declare the statements made herein are true and complete and shall form part of my application for coverage. I hereby authorize any physician, health care provider, other person, hospital or institution to release to Group Medical Services and/or its authorized agents, representatives, affiliates or other service providers (collectively "GMS") any information covering my medical history, symptoms, treatment, examination, diagnosis and/or services rendered to myself or any of my dependants herein listed.

For the purposes of administering any GMS benefits, products or services (collectively "benefits") and/or determining eligibility for benefits, I authorize GMS to:

(a) collect, store and use any personal information which I have provided to GMS or personal information obtained pursuant to clause (b); and/or

(b) obtain personal information about me (or any other person listed herein) from, or disclose such personal information to: my government health plan; the operator of any hospital, clinic, or other health facility; a doctor or other health care provider; any insurance company; or any other service provider or third party as may be reasonably required for the purposes described above.

I understand that, whether before or after my application, any misrepresentation, incorrect or concealed information or failure to fully complete all sections of the application may void my coverage. I declare that, if I am signing on behalf of any person(s), I have the authority to sign on behalf of such person(s) listed herein and confirm that each of the above declarations and authorizations are also provided on behalf of such person(s).

I warrant that neither I nor any person herein listed have any additional coverage through any insurer other than the information listed herein. Should I or any person herein listed subsequently obtain additional coverage through any insurer, while covered under this contract, I will immediately advise GMS in writing. I hereby authorize GMS to coordinate any eligible expenses with any additional insurer that I or any person herein listed may have coverage under.

Applicant's Signature	Date *(DD/MM/YYYY)*
X	

J. For Broker or Agent Use Only

The undersigned hereby confirms that appropriate disclosure, as set out in the Canadian Council of Insurance Regulators: Advisor Disclosure document, has been made to the client regarding: (a) the company or companies represented; (b) that a commission is received for sale of this insurance product; (c) that additional compensation may be received in the form of bonuses; (d) any conflict of interest with respect to this transaction.

Agent Signature **X** _____

Agent #1 | Agent #2 | Split A1% / A2% | For Office Use: | Effective Date: DD/MM/YYYY | GMS ID: