GMS

GMS GROUP ADVANTAGE®
Group Insurance Application

The application package (application, enrolment forms and PAD agreement) and a cheque for first month's premium must be received at GMS head office ten business days before the requested effective date of this plan. Please make sure information is complete and accurate to avoid delaying the effective date.

A. Applicant Information

Employer/Group Legal Name ☐ New Application ☐ Revision to Plan	Operating Name *(complete if different from legal name)*		
Mailing Address	City	Province	Postal Code
Business Location	City	Province	Postal Code
Phone ( )	Fax ( )		
Nature of Employer's Business	Date Established *(DD/MM/YYYY)*		

Legal Status

☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Association ☐ Other *(please indicate)* _____

Full names of Branch Affiliates or Subsidiaries *(list all that are to be included under one monthly invoice)*

Affiliated	Subsidiary	Name and Address	# of Employees
☐	☐		
☐	☐		

Group Administrator(s)

Primary	First Name	Last Name	
	Phone ( )	Fax ( )	Email
Secondary	First Name	Last Name	
	Phone ( )	Fax ( )	Email

B. Waiting Period & Number of Employees

The waiting period for new employees hired after effective date of this plan is 3 months unless otherwise specified: _____ month(s)

☐ Permanent Full-time #	☐ Permanent Part-time #	☐ Contract or Seasonal #

C. Selection of Coverage *(GMS Group Advantage Dental Plans must be purchased with a Group Advantage Health Plan)*

Premium Calculation: *(for GMS Group Advantage Health and Dental rates, please refer to the GMS Group Advantage Rate Schedule or Quote Tool)*

Please check options for all classes of coverage that apply

Health Coverage
☐ Silver ☐ Gold ☐ Platinum
Dental Coverage
☐ Silver ☐ Gold ☐ Platinum
Maximum: ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000
Please carry subtotals from the Quote Tool to section F.

Group Advantage Plus Coverage	
Life + AD&D	☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ 1xAnnual Salary
Dependant Life	☐ $5,000 (spouse) / $2,500 (dependents) of coverage ☐ $10,000 (spouse) / $5,000 (dependents) of coverage
Traditional Critical Illness ☐ High Severity Critical Illness ☐	☐ $10,000 ☐ $25,000 (Available to groups of 6 -10)
Short Term Disability	☐ Yes ☐ No
Long Term Disability	☐ Yes ☐ No
Second Medical Opinion	☐ Yes ☐ No
	Please carry subtotals from the Quote Tool to section F.

D. Existing Coverage

Is this plan intended to replace any existing coverage?

☐ Yes ☐ No

E. Premium Contributions

	Employer %	Employee %		Employer %	Employee %
Extended Health Care			Dental Care		

	Employer %	Employee %		Employer %	Employee %		Employer %	Employee %
Life/AD&D			Long Term Disability			Critical Illness		
Dependant Life			Short Term Disability			Dep. Critical Illness		
Second Medical Opinion								

If optional coverage for life or critical illness is selected, premiums are 100% employee paid.

F. Payment

Total Monthly Premium

Health $ _____ + **Dental** $ _____ + **Group Advantage Plus** $ _____ + **PST** $ _____ = $ _____
Total Monthly Premium

Choose one of the following payment options.

☐ Pre-authorized Debit *(please attach a Pre-Authorized Debit Agreement and the first month's premium)* ☐ Cheque

Requested Effective Date of this Plan:

1st day of _____ , 20_____

G. Declaration

The applicant hereby declares that the statements and answers contained herein are full, complete and true as of the date hereof and expressly agrees that: (1) such statements and answers shall constitute the application for the contract and form part of the contract, and (2) the coverage shall become effective in accordance with and subject to the policy to be issued to the applicant but in no case shall it become effective until this application has been approved by Group Medical Services (GMS). GMS will not be liable to the applicant or any of the applicant's employees until the application is approved. The applicant understands that Life, AD&D, Dependant Life, Long Term Disability, Short Term Disability and Critical Illness are provided by Assumption Life and that GMS acts as the policyholder for pooled products and has the authority to approve/decline. As such, any policy providing such coverage, if approved by Assumption Life, will be a contract with Assumption Life and the information you have supplied in this application will be provided to and relied on by Assumption Life and included as part of that contract. The undersigned declares that he/she has authority to sign on behalf of the applicant and understands that, whether before or after the date of application, any misrepresentation, incorrect or concealed information or failure to fully complete all sections of the application may void coverage.

Do not terminate any existing coverage until notice has been given in writing that the coverage being applied for is approved by GMS.

Dated at_____ this_____ day of_____ , _____ .

by _____ _____

Applicant Signature *Please print name and title*

Office Use Only: Date Received: DD / MM / YYYY Group #: RSL: Agent #: 1129688

GMS

GMS GROUP ADVANTAGE®
Enrolment/Change Form

Please be sure to complete all sections of this form, then return it to your Plan Administrator.

A. General Information *(to be completed by Plan Administrator)*

❑ New Employee/Member ❑ Re-hire ❑ Termination ❑ Changing Information

If changing information, reason for change:

Employer/Group Legal Name	Operating Name *(complete if different from legal name)*		
Employee/Member Occupation	Class	Regular Hrs/Wk	Annual Earnings
Permanent Full-Time Hire Date *(DD/MM/YYYY)*	Coverage/Change/Termination Effective Date *(DD/MM/YYYY)*		
Re-hire *(If re-hire is within six months, coverage will be effective as of the re-hire date; otherwise the waiting period must be served.)*			
Date Previous Employment Ended *(DD/MM/YYYY)*	Re-hire Date *(DD/MM/YYYY)*		
Signature of Plan Administrator **X**	Date *(DD/MM/YYYY)*		

B. Employee/Member Information - Initial Application or Changing Information *(to be completed by the employee/member)*

First Name	Last Name	Sex ❑ M ❑ F	Date of Birth *(DD/MM/YYYY)*
Address	City	Province	Postal Code
Phone ( )	Email	Provincial Health Care Coverage in Place? ❑ Yes ❑ No	

C. Family Information - Initial Application or Changing Information *(to be completed by the employee/member)*

	First Name	Last *(if different from yours)*	Sex	Date of Birth *(DD/MM/YYYY)*	Provincial Health Care Coverage in Place?	Dependant age 21 or over?[2]
Spouse[1]			❑ M ❑ F		❑ Yes ❑ No	N/A
Dependant			❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No
Dependant			❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No
Dependant			❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No

[1] If your spouse is common-law, please complete the following:
I have been living with and representing the above as my spouse since
DD/MM/YYYY
My common-law spouse and I are financially responsible for all our dependants claimed for insurance purposes.

[2] For each dependant age 21 and over:
- in the case of a student dependant under age 25, please complete the over-age dependant questionnaire available at www.gms.ca.
- in the case of a dependant due to a developmental or physical disability, please attach or enclose a doctor's note or copy of an equivalent document as evidence.

D. 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

Office Use Only: GMS ID# Group # Coverage Effective Date

E. Waiving Benefits *(complete this section to waive benefits if you and your spouse/dependants have coverage under your spouse's plan)*

- ❑ Waive Health for myself and spouse/dependant(s)
- ❑ Waive Dental for myself and spouse/dependant(s)
- ❑ Waive Health for my spouse/dependant(s) ONLY
- ❑ Waive Dental for my spouse/dependant(s) ONLY

Spouse's Insurance Carrier	Plan/Policy Number

Employee Signature	Date *(DD/MM/YYYY)*
X	

NOTE: *If you or your spouse/dependant(s) lose coverage under your spouse's plan, you can enrol in this plan. To enrol, you must complete and submit an enrolment form within 31 days of losing coverage. If you apply after 31 days, you may be required to complete a medical questionnaire to qualify for coverage.*

F. Life Insurance Beneficiary Designation *(complete this section if this group benefit plan includes coverage for Life Insurance)*

Beneficiary First Name	Beneficiary Last Name	Date of Birth *(DD/MM/YYYY)*	% Share		Relationship
				❑ Revocable ❑ Irrevocable	
				❑ Revocable ❑ Irrevocable	
				❑ Revocable ❑ Irrevocable	
				❑ Revocable ❑ Irrevocable	

If the designated beneficiary is a minor, I appoint the following person as trustee.	Relationship

NOTE: *Unless otherwise stipulated or not permitted by law, any beneficiary designation is revocable. If a beneficiary is named irrevocably, please note that his/her consent is required for any request that may affect his/her rights, including a change of beneficiary.*

Complete the following if you are making a change to an Irrevocable Beneficiary. *(The effective date of the beneficiary change will be the date this form is signed.)*

Signature of Previous Irrevocable Beneficiary	Print Name of Previous Irrevocable Beneficiary	Date *(DD/MM/YYYY)*
X		

G. 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 their designated travel assistance representative(s), affiliate, reinsurer, agent, or independent claims administrator acting on behalf of GMS (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.

GMS may, for the purposes of administering any benefits, products or services to be provided pursuant to this policy, for the purposes set out in the GMS privacy statement and for the purposes of determining eligibility for benefits: (a) collect, store and use any personal information about you, which you have provided to GMS, or any personal information which GMS has obtained pursuant to clause (b); and/or (b) obtain personal information about you from, or disclose such personal information to: my government health plan; the operator of any hospital, clinic, or other health facility; a physician 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 in (a) 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) and confirm that each of the above declarations and authorizations are also provided on behalf of such person(s).

I understand my group benefit plan may include but not be limited to coverage for Life, AD&D, Dependant Life, Short Term Disability, Long Term Disability, Critical Illness, Second Medical Opinion, EFAP or other such services as may be determined from time to time. Benefits and services may be provided by an affiliate, reinsurer, agent, or independent claims administrator acting on behalf of GMS. The affiliate, reinsurer, agent or independent claims administrator that GMS has partnered with has the authority and responsibility for assessing and or approving my application for such benefits and services and any claims made thereunder. As such, any information concerning insurance coverage, medical care, advice, treatment or supplies or any other information that may have bearing on the request for benefits or services submitted in conjunction with this policy may be requested and relied upon for determining eligibility of benefits.

In the event of death, I authorize any beneficiary, heir or executor to provide GMS, any insurer and/or reinsurer with all information or authorizations deemed necessary for claims adjudication purposes and for obtaining supporting documents. I authorize any coroner, police force or toxicologist that holds my personal information, including any accident and police investigation reports regarding a claims analysis following death, disability or dismemberment, to exchange such information with GMS, any insurer and/or reinsurer. I also authorize the communication of my personal information (other than of a medical nature) to any private investigator and authorize this private investigator to communicate any information collected regarding me to GMS, any insurer and/or reinsurer.

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 co-ordinate any eligible expenses with any additional insurer that I or any person herein listed may have coverage under.

Employee/Member Signature	Date *(DD/MM/YYYY)*
X	

To avoid delays in processing, make sure all sections of this form are completed in full. When completed, return to your Plan Administrator.

PRE-AUTHORIZED DEBIT (PAD) Agreement

Please complete this PAD Agreement and return it, along with payment for the first month's premium, to: *Administration* at *Group Medical Services, 2055 Albert Street PO Box 1949 Regina, SK S4P 0E3*. The original signed form is required for pre-authorized debits to be authorized.

A. General Information

GMS ID No. *(if applicable)*	Group Plan No. *(if applicable)*	Date *(MM/DD/YYYY)*

Please indicate what type of use this PAD Agreement is for:

☐ Business *(I am an employer paying my employee's premium.)*

Employer Name	Employee Name

☐ Personal *(I am an individual paying my own premium.)*

First Name	Last Name	Date of Birth *(MM/DD/YYYY)*

B. Account Information

Financial Institution Name	Address	
City	**Province**	**Postal Code**

Please include a void cheque with this agreement or fill out the numbers below.

Branch Transit Number	Financial Institution ID Number	Account Number
☐☐☐☐☐	☐☐☐	☐☐☐☐☐☐☐☐☐☐☐☐

Type of Account *(only Canadian accounts are acceptable)*	I request regular monthly payments for the full amount of services delivered to be debited from my account on the	Is this the same account you want your claim payments to be deposited into?
☐ Savings ☐ Chequing	☐ 1st or ☐ 15th *(only choose one date)*.	☐ Yes ☐ No *(If "No", please contact us to set up another account)*

C. Declaration

I/We ("I") authorize Group Medical Services (GMS), and the financial institution designated to begin deductions as per my/our ("my") instructions for monthly regular recurring payments and/or one-time payments following notification by written notice, for all charges arising under my GMS account(s).

I waive my right to receive pre-notification of the amount of the PAD and agree that I do not require advance notice of the amount of PADs before the debit is processed.

This PAD Agreement may be cancelled at any time provided notice is received, in writing, at the address provided above at least 10 business days before the next debit 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 debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

Signature of Authorized Account Holder*	Signature of Authorized Account Holder*
X	**X**
Name *(please print)*	Name *(please print)*

**Where Account Holder's account agreement requires the signature of two or more signing authorities, the signatures of all such persons are required for the purposes of this Pre-Authorized Debit Agreement.*

Please remember the following when using Pre-Authorized Debit:

- Payment for the first month's premium amount must be included with this application.
- You may be subject to an administration charge for each monthly withdrawal.
- Non-Sufficient Funds (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 charge and GMS' standard NSF policy can be found on gms.ca.
- Withdrawal payments will continue until such time as written notice to the contrary is given, in accordance to the right of termination of this PAD Agreement.
- 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 be processed.