

**Please Remember the following when submitting claims:**

- All claims must be submitted within twelve (12) months from the date of service.
- Submit only original itemized receipts. Attach all receipts to this claim form.
- GMS does not return receipts; keep a photocopy of the receipt if necessary.
- Include any required physician referrals or orders.
- Please accumulate \$50 in total expenses before submitting a claim.
- Each form must be completed in full and signed by the Claimant and the Policyholder.
- Complete all sections and submit to:  
Group Medical Services, Attn: Claims #200 – 3303 Hillside Street Regina, SK S4S 7J8.

**Your Administrative Services Only Benefit Plan is provided directly by your Group Policyholder and is not insured by Group Medical Services.**

**A. Employer Information**

Employer Name (Group Policyholder) \_\_\_\_\_ Group Plan No. \_\_\_\_\_  
 Group Administrator Name \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
 Email \_\_\_\_\_

**B. Member Information**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth DD/MM/YYYY Sex:  M  F  
 Address \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_  
 Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone \_\_\_\_\_ Email \_\_\_\_\_  
 GMS ID No. \_\_\_\_\_

**C. Other Coverage Information**

Do you, your spouse, or any dependant(s) have coverage under any other insurance plan?  Yes (please complete below)  No

**If you have coverage through any other insurance plan you must complete this section**

Name of Insured and Start Date of Coverage	Insurer	Policy #	Certificate #	Coverage Check all that apply	Who's Covered Check all that apply
				<input type="checkbox"/> Health <input type="checkbox"/> Vision <input type="checkbox"/> Drugs <input type="checkbox"/> Travel <input type="checkbox"/> Dental	<input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependants

Claims must be submitted through your other insurance plan before submission through the Administrative Services Only Plan.

**D. Claims Information** (If submitting a dental claim, please attach a Standard Dental Claim Form completed by your dentist's office)

First Name	GMS ID No.	Date of Birth	Type of Expense (e.g. Ambulance, Crutches, etc.)	No. of Claims	Total Amount of Claims
		DD / MM / YYYY			
		DD / MM / YYYY			
		DD / MM / YYYY			
		DD / MM / YYYY			
		DD / MM / YYYY			
		DD / MM / YYYY			
<b>Total Health and Dental Claims</b>					<b>\$ (A)</b>

Use this total for line (A) in the following Payment Calculations Section

## E. Declaration

I/We ("I") declare the statements made herein are true and complete. For the purposes of administering any Group Medical Services ("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 Insurance 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 any misrepresentation, or incorrect or concealed information may void my coverage.

I warrant that neither I nor any person herein listed have any additional coverage through any insurer other than the information listed herein and hereby authorize GMS to coordinate any eligible expenses with any additional insurer listed herein.

**X**

Signature of all Claimants 18 years of age and older

DD / MM / YYYY

Date

Group Medical Services respects your privacy. Your personal information is not disclosed to anyone unless written authorization has been provided. Written authorization can be provided by filling out and submitting a Consent to Disclose Personal Information Form, available online at [www.gms.ca](http://www.gms.ca).

## F. Payment Calculations (to be completed by the Plan Administrator)

Total Claim Amount: <i>(Enter the Total Health and Dental Claims amount from Section D. Claims Information)</i>	\$ _____ (A)
Administration Fee: _____ % x (A) <i>(Your Plan Administrator can provide the Administration Fee percentage as detailed in the Group ASO Contract, or contact Group Medical Services at 1-800-667-3699)</i>	\$ _____ (B)
Add lines (A) and (B)	\$ _____ (C)
<i>For Ontario and Newfoundland Residents Only</i> Provincial Premium Tax : <i>(ON: 2% x (C))</i> <i>(NFLD: 4% x (C))</i>	\$ _____ (D)
<i>For Ontario Residents Only</i> Ontario Provincial Sales Tax: <i>(8% x (C))</i>	\$ _____ (E)
<i>For All Provinces</i> GST: <i>(5% x (B))</i>	\$ _____ (F)
<b>Grand Total:</b> <i>((C) + (D) + (E) + (F))</i>	\$ _____ (G)

Please include payment by cheque payable to Group Medical Services (in the amount of **(G)**) with this claim.

## G. Plan Administrator Approval

Eligibility for Administrative Services Only Benefits is determined by the Group Policyholder, therefore it is the Group Policyholder's responsibility to verify Employee and Dependant eligibility prior to claim submissions, to ensure Administrative Services Only claims are Eligible Medical Expenses under the Income Tax Act and that Administrative Services Only Claims have not been previously reimbursed or submitted as deductible expenses.

**X**

Authorized Signature for Group Policyholder

DD / MM / YYYY

Approved by

Date

Print Name and Title