Group Medical Services

GMS Group Advantage®
Group Insurance Application Form

A. Applicant Information

Employer / Group Name ____________ ☐ New Application ☐ Revision to Present Plan *(please check one)*

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

Group Administrator(s)

Primary	Name ____________		Title ____________
	Phone ( ) ____________	Fax ( ) ____________	Email Address ____________
Secondary	Name ____________		Title ____________
	Phone ( ) ____________	Fax ( ) ____________	Email Address ____________

B. Selection of Coverage and Monthly Premium Calculation

Waiting period for new employees hired after effective date of insurance: ☐ 3 months ☐ Other *(please specify)* ____________

☐ Permanent Full-time	# of Employees	☐ Permanent Part-time	# of Employees	☐ Contract or Seasonal	# of Employees	☐ Other	Type	# of Employees

Premium Contributions:

	Employer %	Employee %		Employer %	Employee %
Extended Health Care	____	____	Dependant Life	____	____
Dental Care	____	____	Weekly Indemnity	____	____
Life / AD&D	____	____	Long Term Disability	____	____

Premium Calculation:

Health & Dental Coverage			
Health	☐ Silver ☐ Gold ☐ Platinum	# of Single ____ X Rate ____ # of Family ____ X Rate ____	$ ____ $ ____
Dental	☐ Silver ☐ Gold ☐ Platinum	# of Single ____ X Rate ____ # of Family ____ X Rate ____ *Dental Coverage Maximum* ☐ $500 ☐ $1,000 ☐ $1,500	$ ____ $ ____

Life & Disability Coverage			
Life	☐ Yes ☐ No	Monthly Cost per $1,000:	$ ____
AD&D	☐ Yes ☐ No	Monthly Cost per $1,000:	$ ____
Dependant Life	☐ Yes ☐ No	Monthly Cost per Family:	$ ____
Weekly Indemnity	☐ Yes ☐ No	Monthly Cost per $10:	$ ____
Long Term Disability	☐ Yes ☐ No	Monthly Cost per $100	$ ____
Optional Life	☐ Yes ☐ No	Monthly Cost per $1,000:	$ ____

Subtotal: Health & Dental $ ____________ **Subtotal: Life & Disability $** ____________

* *For GMS Group Advantage® Health and Dental rates, please refer to the supplied Monthly Rate Schedule. For Life & Disability rates, please see your GMS Insurance Broker or Business Development Consultant for a quotation.*

Total Monthly Premium: (**Health & Dental $** ____________ + **Life & Disability $** ____________) + **PST** *(Ontario only)* $ ____________ = **$** ____________ **Total Monthly Premium**

For Office Use Only:	Date Received: DD / MM / YYYY	BDC:	Agent #1:	Agent #2:	Split: A1 % / A2 %

C. Payment Options

Choose one of the following payment options:
- ❑ Pre-authorized Payment *(please attach a Pre-Authorized Debit Agreement and the first month's premium)*
- ❑ Cheque

Requested Effective Date of this Plan: 1st day of ______ MONTH ______, ____ YYYY ____.

Complete application package and the first month premium must be received at GMS Head Office prior to the Requested Effective Date of this Plan.

D. Additional Information

Are any individuals currently receiving disability benefits under a group plan, Workers Compensation Board, or any other source? ❑ Yes ❑ No

Is this plan intended to replace any existing coverage? *(if YES, please complete the following section)* ❑ Yes ❑ No

Benefit Check all that apply	**Name of Current Carrier**	**Effective Date of Present Coverage**
❑ Extended Health Care ❑ Dental Care		DD / MM / YYYY
❑ Life ❑ Weekly Indemnity ❑ Long Term Disability ❑ AD&D ❑ Dependant Life ❑ Optional AD&D ❑ Optional Life		DD / MM / YYYY

E. Declaration

The applicant hereby declares that, to the best of the applicant's knowledge, 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 GMS. Group Medical Services will not be liable to the applicant or any of the applicant's employees until the application is approved. The applicant understands that the Life, AD&D, Dependant Life, Weekly Indemnity and Long Term Disability are provided by The Co-operators Life Insurance Company ("The Co-operators") and that GMS acts only as the administrative agent for The Co-operators in placing and administering such coverage. The Co-operators and not GMS has the authority and responsibility for assessing and approving your application for such coverage and any claims made thereunder. As such, any policy providing such coverage, if approved by The Co-operators, will be a contract with The Co-operators and the information you have supplied in this application will be provided to and relied on by The Co-operators 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 Group Medical Services.

Dated at ____ CITY OR TOWN ____ this ____ DD ____ day of ____ MONTH ____, ____ YYYY ____.

by ______________________________
Applicant Signature

____
Please Print Name and Title