

Instructions

1. Complete all sections in full.
2. Attach the following documents:
 - Official discharge papers from the hospital stating the admission and discharge dates
 - Written confirmation from your physician stating your diagnosis while hospitalized
(When submitting original documents, please be sure to keep a copy for your records)

3. Sign and date the completed form and submit package to Claims at:

Group Medical Services
2055 Albert Street
PO Box 1949
Regina, SK, S4P 0E3

Failure to complete this form in full will delay the processing of your claim. Your claim cannot be processed if this form is incomplete.

A. Member Information

First Name _____ Last Name _____ Date of Birth DD / MM / YYYY
 Address _____ City _____ Province _____ Postal Code _____
 Phone (_____) _____ Email _____ GMS ID No. _____

B. Other Coverage Information

Do you, your spouse, or any dependant(s) have Hospital Cash or equivalent coverage under any other insurance plan? Yes *(Please complete below)* No *(Please proceed to section C)*

If you have coverage through another insurance plan, you must complete this section.

Name of the Insured and Start Date of Coverage	Insurer	Policy #	Certificate #	Who is Covered? Check all that apply
				<input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependants

C. Claim Information

Diagnosis of Illness/Injury _____ Date Illness/Injury Began DD / MM / YYYY
 If Injury, describe how injury occurred _____ Date of Incident DD / MM / YYYY
 Date you were awaiting, wait listed or scheduled for hospitalization or surgery DD / MM / YYYY If cancer related, original date diagnosed with cancer DD / MM / YYYY

Name, Address & Phone Number of your Physician:

Name and Specialty	Address	Phone No.
		(_____) _____
		(_____) _____
		(_____) _____

D. Declaration

I/We ("I") declare the statements made herein are true and complete and shall form part of my claim. 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 third party as reasonably required for the purposes described above. 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. I understand that any misrepresentation, incorrect or concealed information may void my coverage. I declare that, if I am signing on behalf of any person(s), I have 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).

X _____ DD / MM / YYYY
Signature of Claimant **Date**