

A. Applicant Information

Applicant #	First Name	Last Name	Sex	Birthdate	Age
1			M / F	DD / MM / YYYY	
2			M / F	DD / MM / YYYY	

For more than 2 applicants, please complete an additional application form or apply online at www.gms.ca.

Address _____ City _____ Province _____ Postal Code _____

Phone () _____ Email _____

Local Contact and Phone Number in Case of Emergency _____

Physician Information (Complete this section when purchasing any Emergency Medical Insurance)

Applicant #	Physician Name(s)	Phone Number
1		()
2		()

B. Eligibility (Complete this section when purchasing any Emergency Medical Insurance or Trip Cancellation & Interruption Insurance for a trip of greater than \$12,000 in value)

Eligibility Requirement

1. Are you awaiting further tests or treatment for heart disease or have you been diagnosed with congestive heart failure (CHF)?
2. Do you have both heart disease and insulin dependent diabetes and take prescription medication for both?
3. Do you use home oxygen for a heart and/or lung disease?
4. Do you take oral steroids for a lung condition?
5. Do any of the following apply to you: you are under active treatment for cancer, have an aortic or intracranial aneurysm that remains surgically untreated, or have experienced undiagnosed episodes of syncope/fainting or falling?
6. Do you have an ICD (Implantable Cardioverter Defibrillator)?
7. In the past 12 months:
 - a) have you suffered from, been diagnosed with, received new treatment for, or had a recurrence of, or complications relating to any of the following: stroke/TIA, blood clots, atrial flutter, atrial/ventricular fibrillation, peripheral vascular disease, AIDS, any terminal illness, renal failure or gastrointestinal bleeding?
 - b) have you undergone the following procedures: renal dialysis, valve replacement, valve surgery or organ transplant?

If you answered YES to any of the above questions, you are NOT eligible to purchase this plan.

I hereby warrant that I AM eligible to purchase this plan.	Applicant # 1 <input type="checkbox"/> YES	Applicant # 2 <input type="checkbox"/> YES
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C. Medical Questionnaire (Complete this section if you are age 60 or older and are purchasing Single Trip Daily Emergency Medical Insurance)

Medical Questionnaire	Applicant # 1	Applicant # 2
C1. Have you ever suffered from, been diagnosed with, received treatment for, or taken prescription medication for any of the following or undergone any of the following medical procedures: (Please circle each applicable condition/procedure)		
a) heart/cardiovascular disease or condition, heart attack, angina, irregular heartbeat, heart surgery, coronary angioplasty, stenting, bypass, valve replacement or valve surgery?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
b) stroke/TIA, blood clots, aneurysm, peripheral vascular disease, carotid stenosis?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
c) chronic lung disease (e.g. chronic obstructive pulmonary disease (COPD)/emphysema/persistent asthma)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
d) bone marrow or organ transplant?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
e) HIV?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
C2. In the past two years prior to your date of departure from your province of residence, have you suffered from, been diagnosed with, received treatment for or taken prescription medication for: (Please circle each applicable condition/procedure)		
a) cancer (excluding basal cell carcinoma), diabetes, pancreatitis?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
b) chronic kidney disease, liver disease, gastrointestinal disorders (e.g. ulcers, G.I. bleed, bowel obstruction)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
c) epilepsy or seizures, M.S., Lou Gehrig's disease, Parkinson's disease, dementia or Alzheimer's?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
C3. Has it been more than 18 months since your last check-up with a physician?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<p>Rate Category</p> <p>Star: <i>If you have answered NO to all questions, you qualify for Star Rates.</i></p> <p>Select: <i>If you have answered YES to one or two of the conditions or procedures in question C2 or C3, you qualify for Select Rates.</i></p> <p>Standard: <i>If you have answered YES to any condition or procedure in question C1, OR if you have answered YES to three or more conditions or procedures in questions C2 & C3, you qualify for Standard Rates.</i></p>		

OPTIONAL Medical Review (for Single Trip Daily only)			Applicant # 1	Applicant # 2
<p>Applicants may request a review of their medical information.</p> <p>If you are concerned about your coverage due to your specific medical condition(s), GMS offers to prescreen your application. List all medical conditions and/or symptoms you have been diagnosed with, suffered from and/or have been treated for in the last 24 months, including any further treatment or investigation which is pending. Include the original date diagnosed, treatment and any changes in the conditions or symptoms.</p> <p>GMS will review the application and contact the applicant directly.</p>			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Applicant #	Condition or Procedure, Date Diagnosed or Performed	List of Prescribed Medications	Date of Initial Prescription	Date of Most Recent Change

D. Coverage Selection and Premium Calculation

Trip Information *(required for Single Trip, TCI or Baggage)*

Departure Date: DD / MM / YYYY

Return Date: DD / MM / YYYY

Total Trip Length: _____ *(the total number of days for your trip including Departure and Return Dates)*

Emergency Medical Insurance

Applicant # 1

Applicant # 2

Single Trip Daily

Rate Category: Star Select Standard

Deductible: \$ 250 \$ 0 *(add 10% to daily rate)*

Top-Up to an Existing Coverage # of Days of Existing Coverage: _____

GMS Coverage: Effective Date: DD / MM / YYYY

GMS Coverage: # of Days: _____ x Daily Rate *(based on total trip length)* \$ _____

\$

\$

Multi-Trip Annual

30 Day 15 Day

Effective Date of Annual Plan: DD / MM / YYYY

\$

\$

Non-Medical Insurance

Trip Cancellation & Interruption (TCI)

SUM Insured \$ _____

\$

\$

Baggage Loss, Damage & Delay

SUM Insured \$ _____ # of Days _____

\$

\$

Non-Medical Inclusive Single Trip (TCI and Baggage)

SUM Insured \$ _____ # of Days _____

\$

\$

Non-Medical Inclusive Multi-Trip (TCI and Baggage)

30 Day 15 Day

SUM Insured \$ _____

\$

\$

All-Inclusive

All-Inclusive Single Trip
(Medical, TCI, Baggage)

SUM Insured \$ _____ # of Days _____

\$

\$

All-Inclusive Multi-Trip
(Medical, TCI, Baggage)

30 Day 15 Day

SUM Insured \$ _____

\$

\$

Options *(available when purchasing a Non-Medical Insurance or All-Inclusive plan; Multi-Trip options require purchase of a Multi-Trip plan)*

Trip Delay Upgrade
(requires the purchase of TCI)

Single Trip \$ 20 Multi-Trip \$ 50

\$

\$

Increased Per-Item Baggage Limit
(requires purchase of Baggage)

Single Trip \$ 20 Multi-Trip \$ 50

\$

\$

Golf Clubs, Skis, Sports Equipment
(requires purchase of TCI or Baggage)

Single Trip QTY _____ x \$ 25

Multi-Trip QTY _____ x \$ 60

Description of Item(s): _____

\$

\$

\$

\$

Laptops, Computer Equipment
(requires purchase of TCI or Baggage)

Single Trip QTY _____ x \$ 25

Multi-Trip QTY _____ x \$ 60

Description of Item(s): _____

\$

\$

\$

\$

Premium TOTAL

\$

\$

E. Payment

Premium Totals

Applicant #1 \$ _____ + Applicant #2 \$ _____ = \$ _____ **TOTAL Premium** (Rates include applicable sales taxes)

Payment Method Cash Cheque VISA MasterCard

Credit Card Number _____ Expiry Date MM/YY

Signature of Cardholder X _____

Coverage will be effective upon Group Medical Services approval of the application and receipt of the appropriate premium. If an adjustment has been made to your policy and you are not fully satisfied, you will have seven (7) days from confirmation to obtain a full refund, provided you have not travelled under this policy.

F. Coordination of Benefits

Do you have a GMS travel plan, group policy and/or coverage with another Insurer or Credit Card for this trip? Yes No (If Yes, please indicate Existing Coverage below)

Insurer/Credit Card _____ Policy # _____

Insurer/Credit Card _____ Policy # _____

Insurer/Credit Card _____ Policy # _____

G. 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 concerning 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 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, 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.

X _____
Applicant #1 Signature Application Date (DD/MM/YYYY)

X _____
Applicant #2 Signature Application Date (DD/MM/YYYY)