gms

IMMIGRANTS & VISITORS TO CANADA
Application

VTC #

Clear Form

A. Applicant Information

Please choose one:

❑ You are outside Canada. *No waiting period.*

❑ You are in Canada and purchasing this plan to replace an existing Canadian health insurance plan. *No waiting period.*

Date first arrived in Canada:_____ Insurance company: _____

Policy #: _____ Expiry Date: _____

❑ You have been in Canada for **less than 30 days** without a Canadian health insurance plan. *2 day waiting period.*

❑ You have been in Canada for **more than 30 days** without a Canadian health insurance plan. *7 day waiting period.*

Applicant† #	First Name	Last Name	Sex	Date of Birth *(DD/MM/YYYY)*	Age
1			❑ M ❑ F		
2			❑ M ❑ F		

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

Canadian Address *(primary residence while in Canada)*	City	Province	Postal Code

Country of Origin	Email

Name of Emergency Contact in Canada	Emergency Contact Phone ( )

B. Sponsor Information *(a sponsor is a person you authorize to act on your behalf)*

Would you like to add a sponsor to this plan?

❑ Yes ❑ No *(if no, proceed to next section)*

By checking "Yes" you are authorizing GMS (Group Medical Services) to share information about your policy, any claims under your policy, personal health information with your sponsor; and send eligible premium refunds to your sponsor. You can remove your sponsor at any time by contacting GMS or your broker.

Sponsor's First Name	Sponsor's Last Name

Is the sponsor's address the same as the address listed in section A. Applicant Information?

❑ Yes ❑ No *(if no, please fill in the information below)*

Address	City	Province	Postal Code

Home Phone ( )	Alternate Phone ( )	Email

IMPORTANT INFORMATION

- There are **specific expenses that are not covered** by this plan. Make sure you **read the Exclusions to Coverage section** in the policy wording.
- Expenses related to **pre-existing conditions, or symptoms** that happened before your effective date **may not be covered** by this plan. Reading the **details found in the policy wording's Exclusions to Coverage section** is important to understand how they apply to you.
- If there is a change in your health after the application date and prior to the effective date, GMS must be notified and the application updated. A change in your health may affect your eligibility for coverage. Changes to your health that do not affect eligibility will still constitute a change in stability and may limit your available coverage.
- Where this policy is issued to satisfy entry to Canada, GMS reserves the right to notify Citizenship and Immigration Canada if the policy is cancelled.
- If you experience a medical emergency, you must notify the GMS assistance firm prior to treatment, where possible, and no later than 24 hours after receiving medical treatment or being admitted to hospital. Your policy may limit benefits should you not contact the assistance firm.
- In the event of a medical emergency you must call GMS Assistance:
  Toll-free (within Canada and the USA): **1.800.459.6604**
  Collect (from all other locations): **905.762.5196**
- In the event of a claim or refund, request documentation confirming travel dates will be required.

C. Eligibility

Eligibility questions determine if you are eligible to purchase a GMS Immigrants & Visitors to Canada Plan. The questions you need to answer are based on your age. Please note, you are not eligible to purchase a plan if you are 80 years of age or older. If you are under 55 years of age, answer questions 1-3. If you are between 55 and 69 years of age, answer questions 1-12. If you are between 70 and 79 years of age, answer questions 1-13. Please note, some words have very specific meanings. Those words are underlined and defined.

ELIGIBILITY QUESTIONS

Between Age **70** and Age **79** *(questions 1-13)*

Between Age **55** and Age **69** *(questions 1-12)*

Under Age **55** *(questions 1-3)*

1. Do you have any reason to seek medical treatment, excluding the regular care of a chronic condition or medical evaluation required to satisfy travel visa requirements?
   Applicant 1 ❑ Yes ❑ No Applicant 2 ❑ Yes ❑ No
2. If you are currently in Canada, have you ever been denied similar coverage offered by another Canadian insurer?
   Applicant 1 ❑ Yes ❑ No Applicant 2 ❑ Yes ❑ No
3. If you are currently in Canada, have you had more than $5,000 in medical treatment in the last 12 months while in Canada?
   Applicant 1 ❑ Yes ❑ No Applicant 2 ❑ Yes ❑ No
4. Are you:
   a. expecting medical treatment for heart disease;
   b. waiting for a test(s) for a suspected heart condition; and/or
   c. taking prescription drugs for heart disease while taking insulin to treat diabetes?
   Applicant 1 ❑ Yes ❑ No Applicant 2 ❑ Yes ❑ No
5. Do you have an Implantable Cardioverter Defibrillator (ICD)?
   Applicant 1 ❑ Yes ❑ No Applicant 2 ❑ Yes ❑ No
6. Have you fainted or fallen more than once without medical diagnosis (syncope)?
   Applicant 1 ❑ Yes ❑ No Applicant 2 ❑ Yes ❑ No
7. Do you use home oxygen for a medical condition?
   Applicant 1 ❑ Yes ❑ No Applicant 2 ❑ Yes ❑ No
8. Do you take oral steroids to treat a lung condition?
   Applicant 1 ❑ Yes ❑ No Applicant 2 ❑ Yes ❑ No
9. Are you being treated for cancer or have Metastatic Cancer?
   Applicant 1 ❑ Yes ❑ No Applicant 2 ❑ Yes ❑ No
10. Do you have a vascular aneurysm that is surgically untreated?
    Applicant 1 ❑ Yes ❑ No Applicant 2 ❑ Yes ❑ No
11. Have you ever had:
    a. a valve replacement,
    b. kidney (renal) dialysis, or
    c. an organ transplant?
    Applicant 1 ❑ Yes ❑ No Applicant 2 ❑ Yes ❑ No
12. Were you diagnosed; did you receive new medical treatment (e.g. consultation, tests or prescription drugs); or have you had a change in your medical treatment, (e.g. a stop, start or dosage change to a prescription drug, other than a dosage change of Coumadin or Warfarin) for, any of the following conditions in the last twelve (12) months:
    a. Congestive Heart Failure
    b. Atrial flutter
    c. Atrial/ventricular fibrillation
    d. Peripheral vascular disease
    e. Stroke/transient ischemic attack (TIA)
    f. Acquired Immune Deficiency Syndrome (AIDS)
    g. Terminal Illness
    h. Blood Clot(s)
    i. Gastrointestinal Bleeding
    Applicant 1 ❑ Yes ❑ No Applicant 2 ❑ Yes ❑ No
13. Do you need help from another person(s) with activities of daily living (ADL)?
    Applicant 1 ❑ Yes ❑ No Applicant 2 ❑ Yes ❑ No

DEFINITIONS

activities of daily living (ADL): activities such as personal hygiene and grooming; dressing and undressing; self-feeding; functional transfers (getting into and out of bed or a wheelchair, getting onto or off the toilet, etc); and bowel and/or bladder management that you require daily assistance with.

chronic condition(s): is a condition that continues to exist for a long period of time or is expected to exist for a long period of time.

heart disease: Any disease of the heart including, but not limited to: angina, irregular heartbeat, heart attack, congestive heart failure, ischemic heart disease, valvular heart disease, and myocardiopathy. Heart disease does not include hypertension or high cholesterol.

medical condition(s): are any irregularities to your health such as an illness, injury or emotional, psychological or psychiatric condition(s):

a. for which you receive medical treatment or medical consultation;

b. related to undiagnosed symptoms for which you received medical treatment or medical consultation; or

c. related to undiagnosed symptoms which would have caused an ordinary person to seek medical treatment or medical consultation.

medical consultation: a meeting with a physician to discuss and evaluate symptoms to diagnose a medical condition, illness or injury. It also includes meeting with a physician to evaluate your progress and medical treatment of a medical condition, illness or injury.

medical treatment: any medical, therapeutic or diagnostic measure prescribed or recommended by a physician in any form, including; prescription medication; investigative testing; in-hospital care; surgery; or other prescribed or recommended action directly referable to the applicable condition, symptom or problem.

oral steroids: are steroids that are swallowed to treat a lung condition. They do not include steroids that are inhaled to prevent asthma attacks or to temporarily treat and relieve inflammation of the airway.

regular care: medical treatment or medical consultation that is not a medical emergency. This includes but is not limited to: routine or general physical examinations and/or medical checkups, use of prescription medication, routine blood work, or routine tests.

terminal illness: a disease that cannot be cured and is reasonably expected to result in death.

You must truthfully answer "NO" to all eligibility questions for your age to be eligible to purchase a plan.

D. Travel Information

Applicant #	Effective Date of Coverage *(DD/MM/YYYY)*	Expiry Date of Coverage *(DD/MM/YYYY)*	Length of Coverage *(number of days - include effective & expiry dates)*
1			
2			

NOTE: *GMS Immigrants & Visitors to Canada Plans are available to a maximum of 365 days, including all extensions. For policies less than 365 days, an extension to your trip may be requested by contacting your broker or info@gms.ca. To be eligible to extend your policy you must not have incurred any medical services during your trip.*

E. Premium Calculation *(refer to the GMS Immigrants & Visitors to Canada brochure for daily rates)*

Applicant #	Deductible	Daily Rate for Amount of Insurance Chosen	Number of days purchased *(from Section D.)*	Premium
1	❑ $1,000 ❑ $500 ❑ $100 ❑ $0	$ _____ x	0	$ 0.00
2	❑ $1,000 ❑ $500 ❑ $100 ❑ $0	$ _____ x	0	$ 0.00
Amount of Insurance	❑ $25,000 ❑ $50,000 ❑ $100,000 ❑ $150,000		Total Premium	$ 0.00

F. Payment Option

Payment Method	Credit Card Number	Expiry Date (MM/YY)	Signature of Cardholder
❑ Cash ❑ Cheque ❑ Visa ❑ MasterCard			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, institution, or insurance company to release to Group Medical Services and/or its authorized agents, representatives, affiliates or other service providers (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.

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, 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.

I agree that my electronic signature in this agreement has the same legal effect as handwritten signatures. Electronic signatures include any information in electronic form that a party has created or adopted in order to sign a document and that is in, attached to, or associated with the document, including signatures sent by fax or email.

Signature of Applicant #1	Date *(DD/MM/YYYY)*	Signature of Applicant #2	Date *(DD/MM/YYYY)*
X		X	

H. For Broker/Agent Use Only

The undersigned hereby confirms that appropriate disclosure, as set out in the Canadian Council of Insurance Regulators: Advisor Disclosure document, has been made to the client regarding: (a) the company or companies represented; (b) that a commission is received for sale of this insurance product; (c) that additional compensation may be received in the form of bonuses; (d) any conflict of interest with respect to this transaction.

Agent Signature X _____

Agent #1 _____ Agent #2 _____ Split A1% / A2% For Office Use Effective Date DD/MM/YYYY GMS ID _____