OVER-AGE DEPENDANT
Questionnaire

This form is to be completed by the Policyholder, or in the case of a group coverage, the Plan Member.
Please return the completed questionnaire to GMS at 2055 Albert Street PO Box 1949 Regina, SK S4P 0E3

A. Policyholder/Plan Member Information

First Name	Last Name	GMS ID Number

B. Dependant Information

First Name	Last Name	Date of Birth *(DD/MM/YYYY)*

Address *(if different from Policyholder/Plan Member)*

C. Policyholder/Plan Member Questionnaire

1. Is the disabled dependant currently residing with you 365 days a year?
   ❑ Yes ❑ No *(If "No", please provide an explanation)*

2. Has the disabled dependant ever been employed?
   ❑ Yes ❑ No *(If "Yes", please provide the most recent date of employment and describe the type of work)*

3. Is the disabled dependant eligible for benefits under a government plan?
   ❑ Yes ❑ No *(If "Yes" please provide a complete list of coverage details)*

4. Is the disabled dependant eligible for health or dental benefits though another insurer?
   ❑ Yes ❑ No *(If "Yes" please provide a complete list of coverage details)*

5. Are you the sole means of financial support for the disabled dependant?
   ❑ Yes ❑ No *(If "No", please explain)*

D. Physician Questionnaire

Name	Phone ( )	Email	
Address	City	Province	Postal Code

1. What is the clinical diagnosis? Please indicate if congenital, or acquired mental or physical disability.

2. Please indicate the date the of diagnosis. *(DD/MM/YYYY)*

3. When was the patient last examined? *(DD/MM/YYYY)*

4. How does the disability restrict the patient's ability to engage in normal activities? Are the restrictions permanent or temporary disabilities? Please explain.

5. What type of work is the patient able to perform?

6. Please provide the date the patient has been unable to work or attend full-time educational training. *(DD/MM/YYYY)*

7. What is the prognosis?

Physician's Signature **X**	Date *(DD/MM/YYYY)*

E. Declaration *(for Policyholder/Plan Member)*

I declare the statements made herein are true and complete. I also declare that I am the guardian, caregiver, and/or parent of the dependant. 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 covering my dependant's medical history, symptoms, treatment, examination, diagnosis and/or services rendered to my dependant 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 my dependant (or any other person listed herein) from, or disclose such personal information to: my dependant's 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, incorrect or concealed information or failure to fully complete all sections of the questionnaire may void my coverage and my dependant's 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 understand that I may be required to complete this form on an annual basis.

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.

Policyholder/Plan Member Signature **X**	Date *(DD/MM/YYYY)*