PERSONAL HEALTH COVERAGE
Family Member Application

As the policyholder, you're required to complete and sign this application on behalf of the family member(s) you wish to add to your plan. In doing so, you're providing consent on their behalf for GMS to use the information provided to determine rates and eligibility. Premiums may be adjusted to reflect the age of the oldest person to be insured and medical conditions/history disclosed in this application. Certain benefits may be excluded or coverage declined based on this application.

A. Policyholder Information

First Name	Last Name	Date of Birth	GMS ID no.

Persons to be Insured* *(collectively referred to as Applicants)*	**First Name**	**Last Name**	**Gender** *(M/F)*	**Date of Birth** *(DD/MM/YYYY)*	**Valid provincial health coverage?** *(required)*	**Same permanent address as policyholder?** *(required)*	**Student?†**
1. Spouse/ Common Law					❑	❑	N/A
2. Dependant					❑	❑	❑
3. Dependant					❑	❑	❑
4. Dependant					❑	❑	❑
5. Dependant					❑	❑	❑

**Families with six or more people must complete and attach an additional application form.*

†*Students between the age of 21 and 24 must be attending a full-time educational training program when applying. Verification of over-age dependants will be requested annually. For permanently disabled dependants age 21 and older, medical verification will be requested. The Over-Age Dependant form can be found at gms.ca/forms.*

Reason for adding family member(s):

❑ Marriage/common law ❑ Retirement ❑ Left employer plan ❑ Birth/adoption of child ❑ Other (please explain)

Date of reason indicated above *(DD/MM/YYYY)* _____

B. Other Insurance Coverage

Does anyone on the application have coverage with GMS or another insurer **that will continue in addition to this plan**? ❑ Yes ❑ No

Insurance Company Name	**Name of Policyholder**	**Coverage Type**	**Benefits Included** *(check all that apply)*	**Plan Type**
		❑ Single ❑ Couple ❑ Family	❑ Health ❑ Drug ❑ Dental ❑ Travel	❑ Group ❑ Individual
		❑ Single ❑ Couple ❑ Family	❑ Health ❑ Drug ❑ Dental ❑ Travel	❑ Group ❑ Individual

C. Medical Information

C1. Health Conditions

In the past two years, has any new applicant consulted a physician or specialist about, suffered from, been diagnosed with, received treatment or taken prescription drugs for any of the following conditions? *(Select all that apply and provide details)*

Heart attack / congestive heart failure / angina / irregular heartbeat / other heart conditions	❑ Yes ❑ No
Stroke / TIA / blood clots	❑ Yes ❑ No
Aneurysm / peripheral vascular disease / other vascular condition	❑ Yes ❑ No
Home oxygen therapy / COPD / other lung condition excluding asthma	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No
Liver disease / kidney disease and/or failure / bladder disorder	❑ Yes ❑ No
Gastrointestinal disorder / Crohn's / colitis / IBS	❑ Yes ❑ No
Cancer / tumour / any terminal disease	❑ Yes ❑ No
AIDS / HIV	❑ Yes ❑ No
Arthritis / rheumatism / musculoskeletal disorder / other bone, joint or muscle condition	❑ Yes ❑ No
Any other disease / disorder / condition or physical impairment *(Please specify below)*	❑ Yes ❑ No
Two or more episodes of fainting or falling? *(Please specify below)*	❑ Yes ❑ No

If you answered "Yes" to any condition listed above, please explain in the next section.

Applicant First Name	Medical Condition	Date Diagnosed *(DD/MM/YYYY)*	Date of Last Change in Treatment *(DD/MM/YYYY)*	Treatment Received or Expected

Sections C2. and C3. are **not required** if you have a **BasicPlan** only or a **BasicPlan with Dental Care** only.

C2. Health Practitioners

In the past two years, has any new applicant consulted, received treatment or been advised to seek treatment from a chiropractor, physiotherapist, massage therapist, psychologist, podiatrist, or acupuncturist? ❑ Yes ❑ No

C3. Future Procedures

a) Is any new applicant on a waiting list, scheduled for or awaiting hospitalization or surgery? ❑ Yes ❑ No
b) Have any tests or exams been advised by a doctor, but not yet completed? ❑ Yes ❑ No

If you answered "Yes" in either section above, please explain in the next section.

Applicant First Name	Medical Condition	Type of Treatment	Expected Date of Treatment *(DD/MM/YYYY)*

Section C4. is **only required** if you have a **Basic Prescription Drug** or **Enhanced Prescription Drug** option or if you've indicated **diabetes** in the conditions above.

C4. Prescription Drug Use

In the past two years, has anyone on the application been prescribed or taken drugs to treat a medical condition? ❑ Yes ❑ No
If you answered "Yes", please explain in the next section.

Applicant First Name	Drug Identification Number (DIN) or Prescription Name and Dosage	Medical Condition	Length of Time Used	Authorized Refills
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No

D. Annual Payment Option *(Complete this if you pay your premium annually)*

D1. Rate Calculation

Rates will be calculated by GMS at the time the application is processed and based on the effective date chosen. Changes made during the policy period will be prorated based on the remaining months before your plan expires. Changes may be subject to medical rating based on the information provided in Section C. GMS will provide confirmation that your application has been processed, including the additional premium owed, and the effective date of the change. For a quote prior to submitting your application please contact info@gms.ca.

NOTE: If the premium amounts below are left blank, or GMS calculates a different new monthly premium than the amount shown, GMS will contact the policyholder to confirm the new monthly premium owing prior to processing payment.

Current Annual Premium	New Annual Premium	Difference Owed
$	$	$

D2. Effective Date of Change(s) *(The effective date chosen must be in the future.)*

❑ Please make the change(s) effective _____*(DD/MM/YYYY)*; or
❑ Please make the change(s) effective on my renewal date.

D3. Payment Details

Payment Amount *(From Difference Owed in D1)*
$ ❑ Cash ❑ Cheque ❑ Visa ❑ MasterCard

Credit Card Number	Expiry Date *(MM/YY)*	Signature of Cardholder
		X

E. Monthly Payment Option *(Complete this if you pay your premium monthly)*

If there has been a change in your financial institution or your banking information, please attach a void cheque to this form.

E1. Rate Calculation

Rates will be calculated by GMS at the time the application is processed and based on the effective date chosen. Changes may be subject to a medical rating based on the information provided in Section C. GMS will provide confirmation that your application has been processed, including the new monthly payment amount, and the effective date of the change. For a quote prior to submitting your application please contact info@gms.ca.

NOTE: If the new monthly premium amount below is left blank, or GMS calculates a different new monthly premium than the amount shown, GMS will contact the policyholder to confirm the new monthly premium owing prior to processing payment.

Current Monthly Premium	New Monthly Premium
$	$

E2. Effective Date of Change(s)

❑ Please make the change(s) effective on my next scheduled pre-authorized invoice date.

NOTE: GMS must be notified at least 10 business days in advance in order to process the change(s) so they are effective on your next scheduled invoice date. Less than 10 business days notice will result in the change(s) being effective on the following pre-authorized invoice date.

❑ Please make the change(s) effective on my renewal date.

E3. Pre-Authorized Debit (PAD) Agreement

I/We ("I") authorize Group Medical Services (GMS), and the financial institution designated to continue deductions as per my/our ("my") instructions for monthly regular recurring payments, and/or one-time payments from time to time, for payment of all charges arising under my GMS account(s). Regular monthly payments for the full amount of services delivered will continue to be debited from my account on my regular scheduled withdrawal date.

I waive my right to receive pre-notification of the amount of the PAD and agree that I do not require advance notice of the amount of PADs before the debit is processed.

This PAD Agreement may be cancelled at any time provided notice is received, in writing, at the address provided below at least 10 business days before the next debit is scheduled to be processed. Please contact our office or visit our website to obtain a cancellation form.

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

Signature of Authorized Account Holder* **X**	Signature of Authorized Account Holder* **X**
Name *(please print)*	Name *(please print)*

** Where account holder's account agreement requires the signature of two or more signing authorities, the signatures of all such persons are required for the purposes of this PAD Agreement.*

F. Policyholder 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 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 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 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.

Policyholder's Signature *(on behalf of all Applicants)* **X**	Date *(DD/MM/YYYY)*

For broker or 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%