

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* <i>(collectively referred to as Applicants)</i>	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				<input type="checkbox"/>	<input type="checkbox"/>	N/A
	2. Dependant				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	3. Dependant				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	4. Dependant				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	5. Dependant				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<small>*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 <a href="http://gms.ca">gms.ca</a>.</small>							
Reason for adding family member(s):							
<input type="checkbox"/> Marriage/common law <input type="checkbox"/> Retirement <input type="checkbox"/> Left employer plan <input type="checkbox"/> Birth/adoption of child <input type="checkbox"/> 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 <b>that will continue in addition to this plan?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
Insurance Company Name	Name of Policyholder	Coverage Type	Benefits Included <i>(check all that apply)</i>	Plan Type
		<input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family	<input type="checkbox"/> Health <input type="checkbox"/> Drug <input type="checkbox"/> Dental <input type="checkbox"/> Travel	<input type="checkbox"/> Group <input type="checkbox"/> Individual
		<input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Family	<input type="checkbox"/> Health <input type="checkbox"/> Drug <input type="checkbox"/> Dental <input type="checkbox"/> Travel	<input type="checkbox"/> Group <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke / TIA / blood clots	<input type="checkbox"/> Yes <input type="checkbox"/> No
Aneurysm / peripheral vascular disease / other vascular condition	<input type="checkbox"/> Yes <input type="checkbox"/> No
Home oxygen therapy / COPD / other lung condition including asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently taking an oral steroid to treat a lung condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver disease / kidney disease and/or failure / bladder disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gastrointestinal disorder / Crohn's / colitis / IBS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer / tumour / any terminal disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
AIDS / HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis / rheumatism / musculoskeletal disorder / other bone, joint or muscle condition	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other medical, psychological, or other condition not otherwise listed? (Please specify below)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Two or more episodes of fainting or falling? (Please specify below)	<input type="checkbox"/> Yes <input type="checkbox"/> 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

### 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. Past and Future Procedures/Hospitalizations

a) Is anyone applying for an upgrade 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

c) Have you been hospitalized more than two times in the past two years?  Yes  No

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

**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
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

**D. Annual Payment Option** *(Complete if you pay your premium annually)***D1. Rate Calculation**

Rates will be calculated by GMS at the time the request 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 change request has been processed, including the additional premium owed, and the effective date of the change. For a quote prior to submitting your request please contact info@gms.ca.

**GMS will calculate applicable premiums and will communicate the new amount and effective date upon approval.**

**D2. Effective Date of Change(s)**

Approved changes will take effect on your renewal date

**D3. Payment Details**

To be calculated by GMS and confirmed before processing

Cheque  Visa  MasterCard

Credit Card Number	Expiry Date (MM/YY)	Signature of Cardholder <b>X</b>
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**E. Monthly Payment Option** *(Complete 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 change form.**

**E1. Rate Calculation**

Rates will be calculated by GMS at the time the request 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 change request has been processed, including the additional premium owed, and the effective date of the change. For a quote prior to submitting your request please contact info@gms.ca.

**GMS will calculate applicable premiums and will communicate the new amount and effective date upon approval.**

**E2. Effective Date of Change(s)**

Approved changes will take effect on your renewal date.

**E3. Update to Monthly Pre-Authorized Debit (PAD) Amount**

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*	Signature of Authorized Account Holder*
Name (please print) <b>X</b>	Name (please print) <b>X</b>

\*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 Pre-Authorized Debit 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