

**Making Changes to Your Plan** – You may request changes to your health, dental, drug, or add-on coverage by submitting a written request to GMS (letter or email) within 31 days of your policy's effective or renewal date. **1.** Approved changes will take effect at renewal and apply for the full policy year (2.0 rule). **2.** Reimbursements for Additional benefits may be prorated for the remaining term of the policy year, where applicable. **3.** Dental upgrades remain in the same benefit year. **4.** Orthodontic coverage has a 1 year waiting period when upgrading to Year 3 of Tier 4. **5.** Travel days may only be added at renewal while in Canada and do not require medical information. **5.** Additional or single-trip days may be added through GMS Travel Insurance, where underwriting may apply.

<b>A. Applicant Information</b> <i>(Please complete this section in full.)</i>		
First Name	Last Name	GMS ID No.
Date of Birth (DD/MM/YYYY)	Phone (    )	Email

<b>B. Coverage Upgrade</b> <i>(Complete B1 to B4 To upgrade a current plan or modify/add additional coverage.)</i>
<input type="checkbox"/> <b>B1. Upgrade Health Coverage</b> <i>(Please complete Section C.)</i> Select plan type that you'd like to upgrade to: <input type="checkbox"/> Tier 1 <input type="checkbox"/> Tier 2 <input type="checkbox"/> Tier 3
<input type="checkbox"/> <b>B2. Upgrade Drug Coverage</b> <i>(Please complete Section C.)</i> Select plan type that you'd like to upgrade to: <input type="checkbox"/> Tier 1 <input type="checkbox"/> Tier 2 <input type="checkbox"/> Tier 3 <input type="checkbox"/> Tier 4
<input type="checkbox"/> <b>B3. Upgrade Dental Coverage</b> <i>(Please complete Section C.)</i> Select plan type that you'd like to upgrade to: <input type="checkbox"/> Tier 1 <input type="checkbox"/> Tier 2 <input type="checkbox"/> Tier 3
<input type="checkbox"/> <b>B4. Add or Modify Additional Coverage</b> Select the coverage option(s) you want to add to your plan or upgrade: <input type="checkbox"/> Hospital Cash – you must complete Section C. (Medical Information) to add this coverage. <input type="checkbox"/> Travel Days <input type="checkbox"/> 15 days per trip <input type="checkbox"/> 30 days per trip <input type="checkbox"/> 45 days per trip <i>No additional medical information required. Proceed to Section D.</i>

<b>C. Medical Information</b>	
<b>C1. Health Conditions</b>	
In the past two years, has anyone applying for an upgrade consulted a physician or specialist about, suffered from, been diagnosed with, received treatment or taken prescription drugs for any of the following conditions? <i>(Select all that apply and provide details).</i>	
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 <i>(Please specify on next page)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Two or more episodes of fainting or falling? <i>(Please specify on next page)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No

If anyone answered "Yes" to any condition listed on the previous page, please explain below.

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 anyone applying for an upgrade consulted, received treatment or been advised to seek treatment from a chiropractor, physiotherapist, massage therapist, psychologist, podiatrist, or acupuncturist?  Yes  No

First Name	Practitioner	Medical Condition	Number of visits in the last 2 years	Prognoses for recovery

**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 anyone answered "Yes", please explain below.

In the past 2 years, has anyone been prescribed or taken drugs to treat a medical condition and/or for precautionary and/or preventive purposes?  Yes  No

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

\* Please attach a separate sheet for additional information.

## 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 will be based on your upcoming renewal date. Approved changes will take effect on the renewal date and apply for the full policy year. Changes may be subject to medical underwriting based on the information provided in Section C. GMS will provide confirmation once your change request has been processed, including any 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 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

Visa     MasterCard

Credit Card Number

Expiry Date (MM/YY)

Signature of Cardholder

X

## 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 will be based on your upcoming renewal date. Approved changes will take effect on the renewal date and apply for the full policy year. Changes may be subject to medical underwriting based on the information provided in Section C. GMS will provide confirmation once your change request has been processed, including any 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 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 begin 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 withdrawn from my account on my 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 withdrawal is processed.**

This PAD Agreement may be cancelled at any time provided notice is submitted through my customer portal as a Service Request at least 10 business days before the next withdrawal is scheduled to be processed. Please contact our office or visit our website for support .

I have certain recourse rights if any withdrawal does not comply with this agreement. For example, I have the right to receive reimbursement for any withdrawal 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 Pre-Authorized Debit Agreement.

## F. Communication Consent

I would like to receive email about special offers, promotions and opportunities to provide feedback about GMS products and services.  Yes  No

### 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 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 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.

Applicant's Signature <b>X</b>	Date (DD/MM/YYYY)
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### H. 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	<input type="text"/>	Agent #2	<input type="text"/>	Split	<input type="text" value="A1% / A2%"/>	For Office Use:	Effective Date:	<input type="text" value="DD/MM/YYYY"/>	GMS ID:	<input type="text"/>
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