



SASKATCHEWAN RETIREES ASSOCIATION
Health, Dental & Optional Add-On Travel Enrolment Form

Please complete and return this form to: *Saskatchewan Retirees Association Inc. (SRA), Walter Scott Building, 3085 Albert Street, Regina, SK, S4S 0B1*

A. Retiree Information (Please Print Clearly)			
Retirement Date (DD/MM/YYYY)			
Effective Date (DD/MM/YYYY) <i>(Must be within 60 days of retirement. Enrolment must be received within 60 days of retirement to guarantee eligibility.)</i>			
Are You a Member of the SRA? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(please complete and enclose an SRA Membership Application)</i>			
First Name	Last Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (DD/MM/YYYY)
Address	City	Province	Postal Code
Phone ()	Email	Provincial Health Care Coverage in Place? <input type="checkbox"/> Yes <input type="checkbox"/> No	

B. Coverage Selection			
Extended Health (Choose One)	<input type="checkbox"/> Single \$125.68/month	<input type="checkbox"/> Couple \$250.37/month	<input type="checkbox"/> Family \$297.61/month
<input type="checkbox"/> With \$1,700 Drug max	<input type="checkbox"/> Single \$160.44/month	<input type="checkbox"/> Couple \$320.05/month	<input type="checkbox"/> Family \$380.42/month
<input type="checkbox"/> With \$2,500 Drug max	<input type="checkbox"/> Single \$215.58/month	<input type="checkbox"/> Couple \$430.58/month	<input type="checkbox"/> Family \$511.77/month
<input type="checkbox"/> With \$3,500 Drug max			
Dental (Choose One)	<input type="checkbox"/> Single \$55.02/month	<input type="checkbox"/> Couple \$109.98/month	<input type="checkbox"/> Family \$118.66/month
<input type="checkbox"/> With \$1,200 max	<input type="checkbox"/> Single \$91.15/month	<input type="checkbox"/> Couple \$182.20/month	<input type="checkbox"/> Family \$209.55/month
<input type="checkbox"/> With \$2,000 max			

Already have Extended Health Coverage? If you do, you may select Dental Coverage. If you do not, you must select Extended Health Coverage above.

C. Optional Add-on Travel Days: Monthly Cost (Must Complete Attached Medical Questionnaire)			
Coverage	15 Extra Days	30 Extra Days	90 Extra Days
Single	<input type="checkbox"/> \$7.39/month	<input type="checkbox"/> \$12.87/month	<input type="checkbox"/> \$44.14/month
Couple	<input type="checkbox"/> \$14.81/month	<input type="checkbox"/> \$25.80/month	<input type="checkbox"/> \$88.48/month
Family	<input type="checkbox"/> \$17.60/month	<input type="checkbox"/> \$30.66/month	<input type="checkbox"/> \$105.15/month

Premium charged may be subject to tax.

(Rates effective July 1, 2026 - June 30, 2027)

D. Family Information						
	First Name	Last (if different from yours)	Sex	Date of Birth (DD/MM/YYYY)	Provincial Health Care Coverage in Place?	Dependant age 21 or over??
Spouse ¹			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A
Dependant			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependant			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependant			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

continued...

¹ If your spouse is common-law, please complete the following:

I have been living with and representing the above as my spouse since _____ (DD/MM/YYYY). My common-law spouse and I are financially responsible for all our dependants claimed for insurance purposes. I further verify that I am not obligated to provide coverage for my legal spouse.

² For each dependant age 21 and over:

- in the case of a student dependant under age 25, please indicate the educational institution where the child is receiving full-time training:

- in the case of a dependant due to a developmental or physical disability, please attach or enclose a doctor's note or copy of an equivalent document as evidence.

E. Other Coverage Information					
Are you, your spouse or dependant(s) covered by any other insurance plan?					
<input type="checkbox"/> Yes (please complete the following) <input type="checkbox"/> No (please skip to F)					
1	Name of Insured		Start Date of Coverage		End Date of Coverage (if applicable)
	Insurer	Policy No.	Certificate No.	Plan Type <input type="checkbox"/> Group (i.e. employer-sponsored) <input type="checkbox"/> Individual	
	Coverage (check all that apply) <input type="checkbox"/> Health <input type="checkbox"/> Drugs <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Travel			Who Is Covered? (check all that apply) <input type="checkbox"/> Me <input type="checkbox"/> Spouse <input type="checkbox"/> Dependants	
2	Name of Insured		Start Date of Coverage		End Date of Coverage (if applicable)
	Insurer	Policy No.	Certificate No.	Plan Type <input type="checkbox"/> Group (i.e. employer-sponsored) <input type="checkbox"/> Individual	
	Coverage (check all that apply) <input type="checkbox"/> Health <input type="checkbox"/> Drugs <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Travel			Who Is Covered? (check all that apply) <input type="checkbox"/> Me <input type="checkbox"/> Spouse <input type="checkbox"/> Dependants	

F. Declaration	
<p>I declare that the information given on this form is true and complete and shall form part of my application for coverage. I hereby authorize any health or dental care provider, other person, hospital or institution to release to GMS and/or their designated travel assistance representative(s) (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.</p> <p>For the purposes of administering any GMS benefits, products or services (collectively "benefits") and/or determining eligibility for benefits, I authorize GMS: (a) to store and use any information which I have provided or information which it obtained pursuant to clause (b); and/or (b) to obtain information from, or disclose information to: my Government Health Insurance Plan; the operator of any hospital, clinic or other health care facility; a doctor or other health care provider; any insurance company; or any other service provider or third party as may be reasonably required.</p> <p>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) and confirm that each of the above declarations and authorizations are also provided on behalf of such person(s).</p> <p>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.</p>	
Signature of Member	Date (DD/MM/YYYY)
X	

Please remember to include a Pre-Authorized Debit Agreement with this enrolment if you will be paying your premium through a monthly pre-authorized debit.

