gms

SASKATCHEWAN RETIREES ASSOCIATION
Travel Medical Questionnaire

Please complete and return this form to: ***Administration at Group Medical Services, 2055 Albert Street PO Box 1949 Regina, SK S4P 0E3 or email info@gms.ca.***

Retiree Information

Retirement Date (DD/MM/YYYY)

Effective Date (DD/MM/YYYY) *(Must be within 60 days of retirement. Enrolment must be received within 60 days of retirement to guarantee eligibility.)*

Are You a Member of the SRA?

❑ Yes ❑ No *(please complete and enclose an SRA Membership Application)*

First Name	Last Name	Sex ❑ M ❑ F	Date of Birth *(DD/MM/YYYY)*

Address	City	Province Please Select	Postal Code

Phone ( )	Email	Provincial Health Care Coverage in Place? ❑ Yes ❑ No

Eligibility for Travel Add On Days

***You* ("*you*" refers to *you* and any dependants covered under your SRA plan) are NOT eligible for coverage if *you* answer yes to any of the following questions.**

Have *you* or any of *your* dependants been diagnosed with, or received *medical treatment* for, any of the following *medical conditions*? Select all that apply.

Heart or Vascular Condition/Stroke/TIA

	Applicant(s)
a) Are *you* waiting for tests or treatment for a heart condition?	❑ Yes ❑ No
b) Surgically Untreated Vascular Aneurysm	❑ Yes ❑ No
c) Congestive Heart Failure (CHF)	❑ Yes ❑ No
d) Implantable Cardioverter Defibrillator (ICD)	❑ Yes ❑ No
e) Do *you* treat *your* Diabetes with Insulin and take a prescription heart drug?	❑ Yes ❑ No
f) In the last 12 months: were *you* diagnosed; did *you* receive new *medical treatment* (e.g. consultation, tests or *prescription drugs*); or was there a change in *your medical treatment* for heart, vascular condition, stroke or TIA (e.g. a stop, start, or dosage change to a *prescription drug* other than a dosage change of Coumadin or Warfarin) for this condition?	❑ Yes ❑ No

Lung Condition(s)

	Applicant(s)
a) Do *you* use home oxygen or take an oral steroid to treat a lung condition?	❑ Yes ❑ No

Please See Medical Questions on Page 2

Cancer/Terminal Illness/Organ Transplant

	Applicant(s)
a) Have *you* had an organ, stem cell, or bone marrow transplant in the past 12 months?	❑ Yes ❑ No
b) Are *you* receiving chemotherapy, radiotherapy, or other *medical treatment* for cancer? Excluding breast or prostate cancer treated exclusively with hormone therapy or routine follow-up visits.	❑ Yes ❑ No
c) Were *you* diagnosed; did *you* receive new *medical treatment* (e.g. consultation, tests or *prescription drugs*; or was there a change in *your medical treatment* (e.g. a stop, start, or dosage change to *prescription drugs*) for *your terminal illness,* cancer or organ transplant in the past 12 months?	❑ Yes ❑ No

Digestive or Urinary Condition

	Applicant(s)
a) In the past 12 months: Were *you* diagnosed; did *you* receive new *medical treatment* (e.g. consultation, tests or *prescription drugs*); or was there a change in *your medical treatment* (e.g. a stop, start, or dosage change to a *prescription drug*) resulting from your liver failure?	❑ Yes ❑ No
b) Have *you* had kidney dialysis in the past 12 months?	❑ Yes ❑ No
c) In the last 12 months: were *you* diagnosed; did *you* receive new *medical treatment* (e.g. consultation, tests or *prescription drugs*); or was there a change in *your medical treatment* (e.g. a stop, start, or dosage change to a *prescription drug*) for a gastrointestinal bleed (GI bleed)?	❑ Yes ❑ No

AIDS

	Applicant(s)
a) In the last 12 months: were *you* diagnosed; did *you* receive new *medical treatment* (e.g. consultation, tests or *prescription drugs*); or was there a change in *your medical treatment?* (e.g. a stop, start, or dosage change to a *prescription drug*) for AIDS?	❑ Yes ❑ No

Defined Words

GMS: Group Medical Services and/or its authorized agents, representatives, affiliates or assistance service provider.

government health plan: any insurance provided by or under the administrative control of any government or governmental agency in accordance with any law (other than The Employment Insurance Act of Canada) or any insurance coverage regulated by any government.

medical condition(s): a disease, illness or injury including symptoms of undiagnosed conditions.

medical treatment: a procedure prescribed, performed or recommended by a physician for a *medical condition*. This includes but is not limited to prescribed medication, investigative testing and surgery.

prescription drugs: a licensed medicine that is regulated by legislation to require a prescription before it can be obtained. The term is used to distinguish it from over-the-counter drugs which can be obtained without a prescription. When referring to a *prescription drug* for a specified condition it includes but is not limited to those prescribed for the direct *medical treatment* of the diagnosed condition, the *medical treatment* of the symptoms associated with the diagnosed condition and the prevention of symptoms associated with the diagnosed condition.

terminal illness: a disease that cannot be cured and is reasonably expected to result in death.

trip(s): the entire period of travel contracted by *you*, and for which a premium was paid.

you or your: any person who is eligible for coverage for any benefit under this policy.

Optional Add-On Travel Days: Monthly

Coverage	15 Extra Days	30 Extra Days	90 Extra Days
Single	❑ $7.39	❑ $12.87	❑ $44.14
Couple	❑ $14.81	❑ $25.80	❑ $88.48
Family	❑ $17.60	❑ $30.66	❑ $105.15

Optional Add-On Travel Days: Annual

Coverage	15 Extra Days	30 Extra Days	90 Extra Days
Single	❑ $88.68	❑ $154.44	❑ $529.68
Couple	❑ $177.72	❑ $309.60	❑ $1,061.76
Family	❑ $211.20	❑ $367.92	❑ $1,261.80

Declaration

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.

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.

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).

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.

Signature of Member	Date *(DD/MM/YYYY)*
X	