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PERSONAL HEALTH COVERAGE
Application

A. Applicant Information

First Name	Last Name

Address	City	Province	Postal Code

Phone ( )	Email	❑ *Yes, I would like to receive email about special offers, promotions and opportunities to provide feedback about GMS products and services.*

Applicant #	First Name	Last Name	Provincial Health Care Coverage in Place?	Sex *(M/F)*	Date of Birth *(DD/MM/YYYY)*	Student*
1 - Applicant			❑ Yes ❑ No			N/A
2 - Co-Applicant			❑ Yes ❑ No			N/A
3 - Dependant			❑ Yes ❑ No			❑
4 - Dependant			❑ Yes ❑ No			❑
5 - Dependant			❑ Yes ❑ No			❑
6 - Dependant			❑ Yes ❑ No			❑

**Check if the Dependant is 21 - 24 years of age and undergoing full-time educational training in the same province as the applicant.*
Families with more than six people - please list the additional people on a separate sheet of paper and attach it to this application.

Are any listed Applicants converting from another GMS Plan? ❑ Yes ❑ No *If you are an existing GMS customer transferring plans within 60 days of your coverage expiring, you do not need to complete Sections F. and G.*

If "Yes," please indicate date previous coverage expires/ends *(DD/MM/YYYY)*

Are any listed Applicants converting from another insurer's group benefit plan? ❑ Yes ❑ No

If "Yes," please indicate previous insurer:	Plan #	Date Benefits Ended *(DD/MM/YYYY)*

B. Coordination of Benefits

Do any listed Applicants have coverage with another insurer? ❑ Yes ❑ No *If "Yes," please complete the section below.*

Applicant #	Insurer	Policyholder	Policy/Certificate #	Coverage *(check all that apply)*
				❑ Health ❑ Drug ❑ Vision ❑ Dental ❑ Travel
				❑ Health ❑ Drug ❑ Vision ❑ Dental ❑ Travel

C. Physician Information

Applicant #	Physician Name	Phone *(include area code)*
		( )
		( )
		( )
		( )

D. Coverage Selection

D1. Select Coverage Type	D2. Select Plan Type	D3. Select Additional Coverage Options (if any)		
❑ Single	❑ OmniPlan®	❑ Basic Prescription Drug	❑ Dental Care	❑ 15-Day Annual travel
❑ Couple	❑ ExtendaPlan®	❑ Enhanced Prescription Drug	❑ Hospital Cash	❑ 30-Day Annual Travel
❑ Family	❑ BasicPlan			❑ 48-Day Annual Travel

E. Coverage Effective Date

Application Date *(DD/MM/YYYY)*	I would like my coverage to be effective on *(DD/MM/YYYY)*

F. Simplified Medical Information

F1. No Medical Information Required

If you are 59 years of age or younger, purchasing a BasicPlan or BasicPlan with the Dental Care additional coverage option, proceed directly to Section H. (Rate Calculation).

F2. Simplified Medical Information

You are required to complete this section if you are:

- purchasing a BasicPlan with Basic or Enhanced Prescription Drug, and/or Hospital Cash;
- 60 years of age and over and purchasing a BasicPlan or a BasicPlan with the Dental Care; or
- purchasing an OmniPlan or ExtendaPlan, provided optional Annual Travel is not selected.

If you are unclear if the following statements apply to you, your spouse or any of your dependants, please complete Section G.

In the last two years, have you, your spouse or any of your dependants:

- received therapeutic services from a health practitioner (chiropractor, physiotherapist, massage therapist, psychologist, podiatrist or acupuncturist); or
- consulted a medical professional for any reason other than a regularly scheduled wellness exam or to address a minor ailment such as a cold or flu or for vaccinations; or
- used one or more prescription drug(s) on a regular basis to treat a diagnosed medical condition, or control undiagnosed symptoms (does not include oral birth control); or
- been diagnosed with a chronic medical condition or been advised to seek further diagnostic testing, surgery or in-hospital care?

❑ Yes, one or more of the above statements apply to me, my spouse and/or my dependants. Please proceed to Section G.

❑ No, none of the above statements apply to me, my spouse and/or my dependants. Please proceed to Section H. to complete your purchase.

G. Detailed Medical Information

You are required to complete this section if you:

- answered Yes to F2. in Section F. (Simplified Medical Information); or
- are purchasing a BasicPlan, OmniPlan or an ExtendaPlan with optional Annual Travel coverage.

G1. Prescription Drug Use

Has any Applicant taken any prescription drug(s) in the past six months or have a prescription for which refills are currently authorized?

❑ Yes ❑ No *If any Applicant answered "Yes" to either of the above questions, please give details below.*

Applicant #	Prescription Name, Strength & Dosage	Medical Condition	Length of Time Used	Refills Authorized
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No

G2. Health Practitioners

Has any Applicant, during the past two years, consulted, received advice or treatment or been advised to seek treatment from a chiropractor, physiotherapist, massage therapist, psychologist, podiatrist or acupuncturist?

❑ Yes ❑ No *If any Applicant answered "Yes" to the above, please give details below.*

Applicant #	Practitioner	Condition	Date Diagnosed *(DD/MM/YYYY)*	Results & Extent of Recovery

G3. Health Conditions and Procedures

Has any Applicant consulted a physician or specialist about, suffered from, been diagnosed with, received treatment or taken prescription drugs for any of the following in the past two years? If "Yes", please circle the condition(s), and indicate which Applicant #.

Conditions & Procedures		Applicant #
Heart Attack / Congestive Heart Failure / Angina / Irregular Heartbeat / Other Heart Conditions	❑ Yes ❑ No	
Stroke / TIA / Blood Clots	❑ Yes ❑ No	
Aneurysm / Peripheral Vascular Disease	❑ Yes ❑ No	
Home Oxygen Therapy	❑ 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	❑ Yes ❑ No	
Any other Disease / Disorder / Condition or Physical Impairment? *(Please specify in G4. below)*	❑ Yes ❑ No	
Two or more episodes of Fainting or Falling? *(Please specify in G4. below)*	❑ Yes ❑ No	

G4. Explanation of Health Conditions

If any Applicant answered "Yes" to any condition in question G3., please explain below.

Applicant #	Condition	Date Diagnosed *(DD/MM/YYYY)*	Results & Extent of Recovery

G5. Future Procedures

a) Is any Applicant on a waiting list, scheduled for or otherwise awaiting hospitalization or surgery? ❑ Yes ❑ No
b) Have any tests or exams been advised by a doctor, but not yet completed? ❑ Yes ❑ No
If any Applicant answered "Yes" to either of the above questions, please give details below.

Applicant #	Condition	Type of Treatment	Expected Date of Treatment *(DD/MM/YYYY)*

H. Rate Calculation *(view the rate schedule for your province on www.gms.ca)*

Health Plan Type Monthly Premium *(OmniPlan®, ExtendaPlan® or Basic Plan)*	Additional Coverage Options					TOTAL
	Basic Prescription Drug Monthly Premium	Enhanced Prescription Drug Monthly Premium	Dental Care Monthly Premium	Hospital Cash Monthly Premium	Annual Travel	
$	+ $	+ $	+ $	+ $	+ $	=

When determining your monthly rate:

- Single means one person; Couple means two people; Family means three or more.
- For Couple or Family, the oldest person on the application determines the rate.
- Based on your medical history, you may be assessed a premium adjustment, excluded for certain benefits, or declined coverage.
- Additional coverage options are only available when purchased with an OmniPlan, ExtendaPlan or BasicPlan purchase.
- Monthly Pre-Authorized Debit (PAD) is available. A $1 per month administration fee will apply.
- A 30% surcharge will apply to all plans with more than six individuals to be insured.

GMS must approve your application and receive the appropriate premium before coverage becomes effective. Waiting periods apply to some benefits. Coverage will be governed by the terms and conditions described in the policy available at www.gms.ca. A copy of the policy will be sent to you upon acceptance of your application by GMS. If an adjustment has been made to your policy and you are not fully satisfied, you will have 30 days from confirmation to obtain a full refund.

I. Payment Options

❑ **Annual** *(Please complete the section below.)* ❑ **Monthly Pre-Authorized Debit** *(Please attach a Pre-Authorized Debit Agreement and the first month's premium.)*

Payment Amount *(Total Monthly Premium as calculated in Section H. x 12)*

$ ❑ Cash ❑ Cheque ❑ Visa ❑ MasterCard

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

J. 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 Insurance 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.

Signature of all Applicants 18 years of age and older	Date *(DD/MM/YYYY)*
X	

K. 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 479796 Agent #2 _____ Split A1% / A2% For Office Use: Effective Date: DD/MM/YYYY GMS ID: _____