PERSONAL HEALTH COVERAGE
Application

BROKER/AGENT: Please complete the designated section at the end of this application to confirm proper disclosure has been made to the client.

A. Applicant Information

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.*

Persons to be Insured† *(collectively referred to as Applicants)*	**First Name**	**Last Name**	**Provincial Health Coverage in Place?**	**Gender** *(M/F)*	**Date of Birth** *(DD/MM/YYYY)*	**Student***
1. Applicant			❑ Yes ❑ No			N/A
2. Spouse/ Common Law			❑ Yes ❑ No			N/A
3. Dependant			❑ Yes ❑ No			❑
4. Dependant			❑ Yes ❑ No			❑
5. Dependant			❑ Yes ❑ No			❑
6. Dependant			❑ Yes ❑ No			❑

†Families with more than six 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.*

B. Coverage Selection

Family Status	Select Plan Type	Additional Coverage Options *(only available when purchased with a plan)*			Provide your plan effective date *(DD/MM/YYYY)*
❑ Single (1 person)	❑ OmniPlan	❑ Basic Prescription Drug	❑ Dental Care	❑ 15-Day Annual Travel	
❑ Couple (2 people)	❑ ExtendaPlan	❑ Enhanced Prescription Drug	❑ Hospital Cash	❑ 30-Day Annual Travel	
❑ Family (3+ people)	❑ BasicPlan			❑ 48-Day Annual Travel	

C. Other Insurance Coverage
(only include personal or group plans that will continue to be in effect at the same time as the GMS health plan)

Does anyone on the application have additional coverage with GMS or another insurer? ❑ Yes ❑ No

Insurance Company Name	**Name of Policyholder**	**Persons Covered under Plan**	**Coverage Type** *(check all that apply)*	**Plan Type**
		❑ Applicant ❑ Spouse ❑ Dependant	❑ Health ❑ Drug ❑ Vision ❑ Dental ❑ Travel	❑ Group ❑ Individual
		❑ Applicant ❑ Spouse ❑ Dependant	❑ Health ❑ Drug ❑ Vision ❑ Dental ❑ Travel	❑ Group ❑ Individual

D. Health Plan Conversion *(if this plan is being used to replace an existing GMS plan or another insurer's health plan please complete the following)*

Is anyone on the application converting from a health plan with similar drug, health and dental benefits? ❑ Yes ❑ No

Insurer	Plan Number	End Date of Coverage *(DD/MM/YYYY)*

E. Medical Information

E1. Health Conditions

In the past two years, has anyone on this application 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	❑ Yes ❑ No
Stroke / TIA / blood clots	❑ Yes ❑ No
Aneurysm / peripheral vascular disease / other vascular condition	❑ Yes ❑ No
Home oxygen therapy / COPD / other lung condition excluding asthma	❑ 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 / other bone, joint or muscle condition	❑ Yes ❑ No
Any other disease / disorder / condition or physical impairment *(Please specify below)*	❑ Yes ❑ No
Two or more episodes of fainting or falling? *(Please specify below)*	❑ Yes ❑ No

If anyone answered "Yes" to any condition listed above, 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

Sections E2. and E3. are **not required** if you're purchasing a **BasicPlan** only or a **BasicPlan with Dental Care** only.

E2. Health Practitioners

In the past two years, has anyone on the application 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

E3. Future Procedures

a) Is anyone on the application 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

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

Section E4. is **only required** if you're purchasing a **Basic Prescription Drug** or **Enhanced Prescription Drug** option or if you've indicated **diabetes** in the conditions above.

E4. 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.

First Name	Drug Identification Number (DIN) or Prescription Name and dosage	Medical Condition	Length of Time Used	Authorized Refills
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No

F. Determine Rate Calculation *(view the rate schedule for your province at gms.ca)*

Health Plan Type Monthly Premium *(OmniPlan®, ExtendaPlan® or BasicPlan)*	Additional Coverage Options					TOTAL
	Annual Travel Monthly Premium	Basic Prescription Drug Monthly Premium	Enhanced Prescription Drug Monthly Premium	Dental Care Monthly Premium	Hospital Cash Monthly Premium	
$	+ $	+ $	+ $	+ $	+ $	= $ 0.00

When determining your monthly rate

- Depending on your province of residence the premium charged may be subject to tax;
- Family means three or more;
- a 30% surcharge will apply to all plans with more than six individuals to be insured;
- for Couple or Family, the oldest person on the application determines the rate; and
- based on your medical history, you may be assessed a premium adjustment, excluded for certain benefits, or declined coverage.

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.

G. Method of Payment *(select annual or monthly payment option)*

❑ Annual Payment

Annual Premium

$ ❑ Cash ❑ Cheque ❑ Visa ❑ MasterCard

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

❑ Monthly Payment Plan Through Pre-Authorized Debit (PAD) *(please provide your account information on the following page)*

Your first month's payment must be made separately by one of the options below. Your bank account will **not** be debited for your first month's payment.
How would you like to make your first month's payment? ❑ Cheque ❑ Cash ❑ Visa ❑ MasterCard *(Please do not send cash in the mail)*

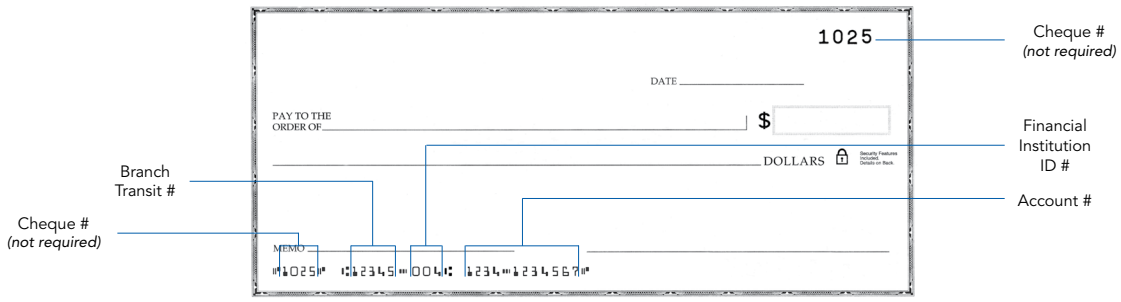
Credit Card Number *(if different than above)*	Expiry Date *(MM/YY)*	Signature of Cardholder
		X

Account Information for ongoing monthly payments *(please include a void cheque or complete banking information below)*

First Name of Account Holder *(if different than applicant)*	Last Name of Account Holder *(if different than applicant)*
Monthly Premium Amount $	Monthly Withdrawal Date ❑ 1st of the month ❑ 15th of the month

Financial Institution ID Number	Branch Transit Number	Account Number
☐☐☐	☐☐☐☐☐	☐☐☐☐☐☐☐☐☐☐☐☐

Is this a change to your PAD Agreement information? *If "Yes", please describe the reason for change.* ❑ Yes ❑ No



Pre-Authorized Debit (PAD) Agreement

I/We ('I") authorize Group Medical Services (GMS), and the financial institution being designated to begin deductions as per my/our ("my") instruction 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).

This Pre-Authorized Debit (PAD) agreement may be cancelled at any time provided notice is received in writing, at the address provided at least 10 business days before the next withdrawal 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 withdrawal does not comply with this agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

The following terms and conditions apply to the processing of a PAD withdrawal.

- For health plans, an administration fee of $1 per month is applied to the amount owed when payment is made using PAD and will be applied to your monthly withdrawal.
- Non-Sufficient Fund (NSF) withdrawals will be handled in accordance with GMS' standard NSF policy and in accordance with the rules laid out by The Canadian Payments Association (CPA).
- Information on the administration fees and GMS' standard NSF policy can be found at gms.ca
- Withdrawal payments will continue until such time as written notice to the contrary is given, in accordance to the right of termination outlined in this PAD Agreement. Any outstanding premium must be paid in full at such time to ensure continued coverage of the product/service payment was being applied to.
- Where a one-time payment is to be processed, funds will be withdrawn on my regular withdrawal date in the month following the service delivered.
- Any change to the information provided under this PAD Agreement or to the product or service for which this PAD Agreement is attached, will require that a new PAD Agreement be completed, signed and submitted to GMS Head Office along with a void cheque. We require receipt of this new PAD Agreement at least 10 business days before the next debit is scheduled to process.

I agree to and understand the terms and conditions set forth and ask that funds begin to be withdrawn from my account as indicated.

Signature of Authorized Account Holder*	Signature of Authorized Account Holder*
X	**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.*

H. 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 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.

Applicant's Signature **X**	Date *(DD/MM/YYYY)*

Before you submit your application

Please make sure you've:

- ☑ **selected your plan effective date**
- ☑ **signed and dated your application**
- ☑ **if paying monthly by PAD, enclosed a cheque for your first month's payment or provided your banking information.**

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 A1% / A2% | For office use: | Effective Date: DD/MM/YYYY | GMS ID: