



Group Medical Services

# Declaration of Student Eligibility Form

Complete all sections and submit to Group Medical Services, Attn: Customer Care, 2055 Albert Street PO Box 1949 Regina, SK S4P 0E3.

## A. Member Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth DD / MM / YYYY  
GMS ID No. \_\_\_\_\_

## B. Dependent Student Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth DD / MM / YYYY  
GMS ID No. \_\_\_\_\_  
Name of School Attending \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_  
Phone Number of Registrar's Office ( \_\_\_\_\_ ) Fax Number of Registrar's Office ( \_\_\_\_\_ )  
Student Status  Full-time  Part-time  Correspondence  Work Term  
Enrolled starting DD / MM / YYYY and ending DD / MM / YYYY

Please attach evidence of eligibility (confirmation of enrolment form, letter from the registrar's office, class schedule, or equivalent) to this form.

## C. Declaration

I/We ("I") declare the statements made herein are true and complete. For the purposes of administering any Group Medical Services ("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 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 any misrepresentation, incorrect or concealed information 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 understand that failure to fully complete all sections, or to return this form to Group Medical Services, may result in the withholding of claims reimbursement.

**X** \_\_\_\_\_ DD / MM / YYYY  
**Signature of Policy Holder / Participant** **Date**

**X** \_\_\_\_\_ DD / MM / YYYY  
**Signature of Dependent Student** **Date**