Group Medical Services

Group Benefit Plans
Group Insurance Application Form

A. Applicant Information

Employer / Group Name ______ ❑ New Application ❑ Revision to Present Plan *(Please check one)*

Mailing Address ______ City ______ Province ______ Postal Code ______

Business Location ______ City ______ Province ______ Postal Code ______

Telephone Number ( ) ______ Fax Number ( ) ______

Nature of Employer's Business ______ Date Established DD / MM / YYYY

Legal Status: ❑ Corporation ❑ Partnership ❑ Proprietorship ❑ Association ❑ Other *(please indicate)* ______

Full names of Branch Affiliates or Subsidiaries *(list all that are to be included all under one monthly invoice)*

Affiliated	Subsidiary	Name and Address	# of Employees
❑	❑		
❑	❑		

Group Administrator(s)

Primary Name ______ Title ______

Phone ( ) ______ Fax ( ) ______ Email Address ______

Secondary Name ______ Title ______

Phone ( ) ______ Fax ( ) ______ Email Address ______

B. Selection of Coverage, Monthly Premium Calculation

Waiting period for new employees hired after effective date of insurance: ❑ 3 months ❑ Other *(please specify)* ______

❑ Permanent Full-time	# of Employees	❑ Permanent Part-time	# of Employees	❑ Contract or Seasonal	# of Employees	❑ Other	Type	# of Employees

Health & Dental Coverage

Custom Health	# of Single ______ X Rate ______	$ ______
	# of Family ______ X Rate ______	$ ______
Custom Dental	# of Single ______ X Rate ______	$ ______
	# of Family ______ X Rate ______	$ ______

ASO ❑ Yes ❑ No Administration Fee ______

** Please attach a schedule of benefits indicating chosen extended health and dental plans.*

Life & Disability Coverage

Life	❑ Yes ❑ No	Monthly Cost per $1,000:	$ ______
AD & D	❑ Yes ❑ No	Monthly Cost per $1,000:	$ ______
Dependant Life	❑ Yes ❑ No	Monthly Cost per Family:	$ ______
Weekly Indemnity	❑ Yes ❑ No	Monthly Cost per $10:	$ ______
Long Term Disability	❑ Yes ❑ No	Monthly Cost per $100	$ ______
Optional Life	❑ Yes ❑ No	Monthly Cost per $1,000:	$ ______

Subtotal: Health & Dental $ ______

Subtotal: Life & Disability $ ______

Total Monthly Premium: (Health & Dental $ ______ **+ Life & Disability $** ______ **) + PST** *(Ontario only)* **$** ______ **= $** ______ **Total Monthly Premium**

For Office Use Only: Date Received: DD / MM / YYYY BDC: ______ Agent #1: ______ Agent #2: ______ Split: A1 % / A2 %

C. Payment Options

Choose one of the following payment options: ❑ Pre-authorized Payment *(complete a Pre-Authorized Debit Agreement)* ❑ Cheque

Requested Effective Date of this Plan: 1st day of ____MONTH____, ____YYYY____.

D. Additional Information

Are any employees or dependants currently hospital confined or otherwise disabled or handicapped? ❑ Yes ❑ No

Is this plan to be in addition to any other group life and/or health plan presently in force? ❑ Yes ❑ No

Is this plan intended to replace any existing coverage? ❑ Yes ❑ No *(If YES, please complete the following section)*

Benefit	Name of Current Carrier	Effective Date of Present Coverage
Extended Health Care		DD / MM / YYYY
Dental Care		DD / MM / YYYY
Life		DD / MM / YYYY
AD & D		DD / MM / YYYY
Optional Life		DD / MM / YYYY
Optional AD & D		DD / MM / YYYY
Dependant Life		DD / MM / YYYY
Weekly Indemnity		DD / MM / YYYY
Long Term Disability		DD / MM / YYYY

Premium Contributions:

	Employer %	Employee %		Employer %	Employee %
Extended Health Care	______	______	Dependant Life	______	______
Dental Care	______	______	Weekly Indemnity	______	______
Life/AD & D	______	______	Long Term Disability	______	______

E. Declaration

The applicant hereby declares that, to the best of the applicant's knowledge, the statements and answers contained herein are full, complete and true as of the date hereof and expressly agrees that: (1) such statements and answers shall constitute the application for the contract and form part of the contract, and (2) the coverage shall become effective in accordance with and subject to the policy to be issued to the applicant but in no case shall it become effective until this application has been approved by GMS. Group Medical Services will not be liable to the applicant or any of the applicant's employees until the application is approved. The applicant understands that the Life, AD & D, Dependant Life, Weekly Indemnity and Long Term Disability are provided by The Co-operators Life Insurance Company ("The Co-operators") and that GMS acts only as the administrative agent for The Co-operators in placing and administering such coverage. The Co-operators and not GMS has the authority and responsibility for assessing and approving your application for such coverage and any claims made thereunder. As such, any policy providing such coverage, if approved by The Co-operators, will be a contract with The Co-operators and the information you have supplied in this application will be provided to and relied on by The Co-operators and included as part of that contract. The undersigned declares that he/she has authority to sign on behalf of the applicant and understands that, whether before or after the date of application, any misrepresentation, incorrect or concealed information or failure to fully complete all sections of the application may void coverage.

Do not terminate any existing coverage until notice has been given in writing that the coverage being applied for is approved by Group Medical Services.

Dated at ____CITY OR TOWN____ this ____DD____ day of ____MONTH____, ____YYYY____.

by ______________________________
Applicant Signature

____
Please Print Name and Title