

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
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		

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)*

<input type="checkbox"/> Permanent Full-time	<input type="checkbox"/> Permanent Part-time	<input type="checkbox"/> Contract or Seasonal	<input type="checkbox"/> Other	Type	# of Employees
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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.

Cost Plus* Yes No

***Cost Plus can only be selected in addition to the Extended Health and/or Dental Care or ASO optional coverages**

Subtotal: Health & Dental \$ _____

Total Monthly Premium: Health & Dental \$ _____ + 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 the following section)

Cheque

Monthly Pre-authorized Payment (PAP) Terms:

I/we ("I") hereby authorize my financial institution to debit my account for all payments to GMS for payment of my/our premiums and any related fees, as may be determined from time to time, and which will be collected monthly in advance. Each payment will be treated as though I had personally issued a cheque authorizing payment to GMS for services as indicated and to debit the amount specified to my/our account. This authorization may be canceled by providing 30 days written notice to GMS, and upon cancelation of this authorization, I will ensure that any unpaid premiums are remitted in full immediately. NSF withdrawals will be handled in accordance with GMS standard NSF policy.

I agree to the Monthly PAP Terms above. If two signatures are required on a cheque, all signing officers must sign.

X _____

Signature

X _____

Signature

Payment for the first month's premium amount must be included with this application.

If you have chosen the Pre-authorized Payment (PAP) option, submit payment using a cheque from your desired PAP bank account OR supply an additional cheque marked 'VOID'.

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? (If YES, please complete the following section) Yes No

Benefit	Name of Current Carrier	Effective Date of Present Coverage
Extended Health Care		DD / MM / YYYY
Dental Care		DD / MM / YYYY

Premium Contributions:

	Employer %	Employee %		Employer %	Employee %
Extended Health Care	_____	_____	Dental Care	_____	_____

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 to any of the applicant's employees until the application is approved. The undersigned understands that he/she has the 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 the 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