

Please complete and return this form to your Group Benefit Plan Administrator.

**A. General Information** *(To be completed by the employer)*

Company \_\_\_\_\_

Employee/Member Occupation \_\_\_\_\_ Class \_\_\_\_\_ Regular hrs/week \_\_\_\_\_ Annual Earnings \_\_\_\_\_

New Employee    Re-hire    Termination    Changing Information   Reason for Change \_\_\_\_\_

Permanent full-time hire date DD/MM/YYYY   Coverage/Change/Termination Effective Date DD/MM/YYYY

If a re-hire<sup>1</sup>, provide the date previous employment ended DD/MM/YYYY and re-hire date DD/MM/YYYY

<sup>1</sup> If re-hire is within 6 months, coverage will be effective as of the rehire date; otherwise, the waiting period must be served.

Signature of Plan Administrator **X** \_\_\_\_\_ Date DD/MM/YYYY

**B. Plan Member/Employee Information** *(To be completed by the employee)*

Employee Name \_\_\_\_\_ Tel. Number ( \_\_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

**C. Applicant/Family Information – Initial Application or Changing Information** *(To be completed by single applicants and applicants with families)*

	Surname	Given Name(s)	Date of Birth	Sex	Provincial Health Care Coverage in Place?	Dependant Child over the age of 21? <sup>2</sup>	Are you, your spouse and/or children covered by any other insurance plan? <i>(Indicate Name of Carrier)</i>	
							Health	Dental
Employee			<u>DD/MM/YYYY</u>	<u>M/F</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	n/a	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse <sup>1</sup>			<u>DD/MM/YYYY</u>	<u>M/F</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	n/a	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child			<u>DD/MM/YYYY</u>	<u>M/F</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child			<u>DD/MM/YYYY</u>	<u>M/F</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child			<u>DD/MM/YYYY</u>	<u>M/F</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child			<u>DD/MM/YYYY</u>	<u>M/F</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

<sup>1</sup> If your spouse is common-law, please complete the following: I have been living with and representing the above as my spouse since DD/MM/YYYY. My common-law spouse and I are financially responsible for all of our children claimed for insurance purposes. I further verify that I am not obliged to provide coverage for my legal spouse.

<sup>2</sup> For each Dependant Child age 21 and over:

- For a Student Dependant under age 25, indicate the educational institution where the child is receiving full-time training: \_\_\_\_\_
- In the case of Dependant due to a developmental or physical disability, please attach or enclose a doctor's note or copy of an equivalent document as evidence.

**For Office Use Only:**   GMS ID#: \_\_\_\_\_   Group #: \_\_\_\_\_   Coverage Effective Date: DD/MM/YYYY

**D. Refusal of Benefits** (Complete this section if you wish to refuse enrolment in this group benefit plan)

I have been given the opportunity to apply for coverage but do not wish to participate, as I have coverage under my spouse's plan. I understand that I will not be able to enroll in these plans at a later date without the mutual consent of my employer and Group Medical Services.

- Waive Health
- Waive Dental
- Waive both Health and Dental

Signature **X** \_\_\_\_\_ Date \_\_\_\_\_  
*Employee/Plan Member Signature*

**E. Life Insurance Beneficiary Designation** (Complete this section if this group benefit plan includes coverage for Life Insurance)

**Life Beneficiary**

Full Name of Beneficiaries	Relationship	% Share

If a designated beneficiary is a minor, I appoint \_\_\_\_\_ as a Trustee.

Your beneficiary designation will not be revoked or changed automatically by any future marriage or divorce. If you wish to change your beneficiary, you will have to make a new designation below.

**Life Beneficiary Change** (the effective date of the Beneficiary change will be the date this form is signed)

- Change of Name Only
- Change of Beneficiary
- Relationship to Plan Member \_\_\_\_\_

Name of Beneficiary (last, first, middle initial) \_\_\_\_\_

Signature of previous irrevocable Beneficiary \_\_\_\_\_

I appoint \_\_\_\_\_ as Trustee to receive any amount due to any beneficiary under the age of 18.

Coverage for Life, AD&D, Dependant Life, Weekly Indemnity and Long Term Disability is provided by Wawanesa Life.

**F. 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 GMS Insurance Inc. and/or their designated travel assistance representative(s) (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 information which I have provided or information obtained pursuant to clause (b); and/or (b) obtain information from, or disclose 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.

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) and confirm that each of the above declarations and authorizations are also provided on behalf of such persons(s).

I understand that the Life, AD&D, Dependent Life, Weekly Indemnity and Long Term Disability are provided by Wawanesa Life ("Wawanesa") and that GMS acts only as the administrative agent for Wawanesa in placing and administering such coverage. Wawanesa 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 Wawanesa, will be a contract with Wawanesa and the information you have supplied in this application will be provided to and relied on by Wawanesa and included as part of that contract.

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 co-ordinate any eligible expenses with any additional insurer that I or any person herein listed may have coverage under.

Signature **X** \_\_\_\_\_ Date \_\_\_\_\_  
*Employee/Plan Member Signature*

To avoid delays in processing, ensure all sections of this form are completed in full. When completed, return to your Group Benefit Plan Administrator.