

A. Applicant Information

New Coverage OR Extension to Existing Coverage

**Applicant #1 is the Student. List spouses and dependants in Applicant #2, 3, & 4. For more than four (4) applicants, please complete an additional application form.*

Applicant #	First Name	Last Name	Sex	Birthdate	Age
*1			M / F	DD / MM / YYYY	
2			M / F	DD / MM / YYYY	
3			M / F	DD / MM / YYYY	
4			M / F	DD / MM / YYYY	

Permanent Address _____

Province _____ Postal Code _____ Permanent/Home Phone (_____) Cell Phone (_____)

B. School/Educational Information

Educational Institution _____ City _____ Province/State _____ Country _____

Have you received a scholarship or waiver of entrance fees? Yes No What type? _____ Includes medical coverage? Yes No

C. Coverage Selection and Payment Information

Choose Plan: StudentPlan Single Couple Family StudentPlan with Sports Coverage Single Couple Family

Effective Date: Start Date of Coverage DD / MM / YYYY Expiry Date of Coverage DD / MM / YYYY # of Months _____ Coverage must be purchased in increments of 4-12 months.

StudentPlan	Single	Couple	Family
Under 35 years of age	\$50.00/month	\$99.00/month	\$149.00/month
35 to 54 years of age	\$77.00/month	\$153.00/month	\$230.00/month

StudentPlan with Sports Coverage	Single	Couple	Family
Under 35 years of age	\$105.00/month	\$154.00/month	\$204.00/month
35 to 54 years of age	\$161.00/month	\$238.00/month	\$315.00/month

Premium Calculation: Monthly Rate from chart above X _____ # of Months = \$ _____ Total Premium

Payment Method: Cash Cheque Visa MasterCard Credit Card # _____ Expiry Date MM / YY

Signature of Cardholder X _____

D. 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 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, 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.

X _____ X _____
Signature of Applicant #1 Date Signature of Applicant #2 Date

E. 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#