

GMS Customers and/or their Broker or Agent can use this form to request a change to a TravelStar® Travel Insurance Policy or to purchase TravelStar® Single Trip as a TOP-UP to existing coverage. To determine any premium changes, contact GMS Customer Care at 1.800.667.3699 or fax this form to 1.306.525.6360. GMS will review and advise if any additional premium is required and will contact the Customer or Agent by telephone. Customers are required to make any additional premium payments using VISA or MasterCard.

**A. Request**

Date of Request DD/MM/YYYY Submitted by:  Broker/Agent  Customer Submitted Via:  Telephone  Facsimile

**B. Policy Holder Information**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth DD/MM/YYYY  
 Address \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_  
 Home Telephone \_\_\_\_\_ Email \_\_\_\_\_  
 Away From Home Telephone (Include area code) \_\_\_\_\_ Cellular \_\_\_\_\_

**C. TravelStar® Date and/or TCI Sum Insured Changes – PRIOR to Departure**

**Complete this section if you wish to change your policy coverage dates and/or TCI Sum Insured PRIOR to your departure.**

Travel Policy # \_\_\_\_\_ TCI Sum Insured \$ \_\_\_\_\_  
 Departure Date DD/MM/YYYY Effective Date DD/MM/YYYY Return Date DD/MM/YYYY Trip Length # of Days

**The daily premium rate will be based upon your total trip length. Please contact GMS Customer Care at 1-800-667-3699 to determine the amount of any premium adjustments. To remove an applicant, please provide written notification to GMS. To add an applicant, please complete a full TravelStar® application.**

**D. TravelStar® Single Trip Daily Emergency Medical - Trip Length Extension – AFTER Departure**

**Complete this section to extend your trip length AFTER your departure. Coverage is limited to the maximum number of days noted by your provincial health plan, unless otherwise authorized in writing by GMS.**

Travel Policy # \_\_\_\_\_  
 Are you applying for this extension a minimum of 2 working days prior to the expiration date of your existing coverage?  Yes  No  
 Have you required medical services in excess of \$500 during your entire trip?  Yes  No  
 Original Departure Date DD/MM/YYYY Original Return Date DD/MM/YYYY Revised Return Date DD/MM/YYYY

**The extension daily premium will be based upon your total trip length. Please contact GMS Customer Care at 1-800-667-3699 to determine the additional premium required.**

**E. TravelStar® Single Trip Daily Emergency Medical - Top-up – AFTER Departure**

**Complete to use TravelStar® Single Trip Daily Insurance as a TOP-UP to existing coverage from a GMS Annual Travel Plan or GMS Individual Health Travel Option.**

GMS ID # or Travel Policy # \_\_\_\_\_ Plan Type \_\_\_\_\_  
 Are you applying for this TOP-UP a minimum of 2 working days prior to the expiration date of your existing coverage?  Yes  No  
 Have you required medical services in excess of \$500 during your entire trip?  Yes  No  
 Original Departure Date DD/MM/YYYY Effective Date of TOP-UP DD/MM/YYYY Return Date DD/MM/YYYY Trip Length # of Days

**Please complete and attach a TravelStar® Travel Insurance Application to this form. The TOP-UP daily premium rate will be based upon your total trip length. Please contact GMS Customer Care at 1-800-667-3699 to determine the premium required. GMS will forward a policy wording to your home address via mail.**

## F. Payment

Please provide payment information for any changes detailed in Sections C or D above.

To determine any premium changes, contact GMS Customer Care at 1-800-667-3699 or fax this form to 1-306-525-6360. GMS will review and advise if any additional premium is required and will contact the Customer or Agent by telephone.

Premium Change \$ \_\_\_\_\_  Visa  MasterCard

Credit Card Number \_\_\_\_\_ Expiry Date \_\_\_\_\_ MM / YY

Signature of Card Holder **X** \_\_\_\_\_

**For Office Use Only:**  Authorization accepted by telephone Received by:

## G. TravelStar® Single Trip Daily Emergency Medical – EARLY RETURN Refund Request

Complete and sign this section if you have returned to your province of residence PRIOR to your original Return Date and have not incurred any claims under this policy.

Original Return Date \_\_\_\_\_ DD / MM / YYYY Actual Return Date \_\_\_\_\_ DD / MM / YYYY

I returned to my province of residence on the Actual Return Date detailed above.

Signature of Customer **X** \_\_\_\_\_

Please provide/attach proof of early return (airline ticket, receipt for goods or other evidence). GMS Customer Care will process your request and forward any required refund less an administrative fee of \$20.00. No refund will be issued for amounts under \$5.

## H. Broker or Agent Information

Complete this section if you are a Group Medical Services Broker or Agent completing this form on your Customer's behalf.

Brokerage or Agency Name \_\_\_\_\_

Agent Name \_\_\_\_\_ Phone Number \_\_\_\_\_ GMS Agent ID # \_\_\_\_\_

Notes:

**For Office Use Only:** Date Received:  Processed by:  GMS ID#: