



Complete all sections and submit to Group Medical Services, Attn: Claims, #200 – 3303 Hillside Street, Regina, SK S4S 7J8.

A. Member Information

First Name _____ Last Name _____ Date of Birth DD/MM/YYYY Sex: M F
Address _____ City _____ Province _____ Postal Code _____
Home Phone (_____) _____ Work Phone (_____) _____ Email _____
GMS ID No. _____ Group Plan No. (if applicable) _____

B. Family Information

Table with 6 columns: First Name, Last (if different from yours), Gender, Date of Birth, Provincial Health Care Coverage In Place?, Disabled Dependant?. Rows include Spouse and multiple Dependant entries.

C. Other Coverage Information

Do you, your spouse, or any dependant(s) have coverage under any other insurance plan? Yes (Please complete below) No (Please proceed to section D)

If you have coverage through another insurance plan, you must complete this section.

Table with 6 columns: Name of the Insured and Start Date of Coverage, Insurer, Policy #, Certificate #, Coverage (Health, Drugs, Dental, Vision, Travel), Who is Covered? (Myself, My Spouse, My Dependants).

D. Declaration

I/We ("I") declare the statements made herein are true and complete. For the purposes of administering any Group Medical Services ("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 any misrepresentation, incorrect or concealed information may void my coverage. I declare that, if I am signing on behalf of any person(s) listed herein, 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

Signature of Policy Holder / Participant

DD / MM / YYYY

Date

X

Signature of Spouse

DD / MM / YYYY

Date

X

Signature(s) of dependent children 18 years of age and older

DD / MM / YYYY

Date

Group Medical Services respects your privacy. Your personal information is not disclosed, except as detailed above, without your expressed written authorization. Written authorization can be provided by filling out and submitting a Consent to Disclose Personal Information Form; available online at www.gms.ca.