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STUDENTPLAN Application

GMS StudentPlan emergency medical insurance cannot be purchased online. Coverage must be purchased by either mailing a completed application to Group Medical Services 2055 Albert Street PO Box 1949 Regina, SK S4P 0E3 or faxing to 306.525.6360

A. Applicant Information

Type of Application
❑ New Coverage ❑ Extension to Existing Coverage

Applicant #	First Name	Last Name	Provincial Health Care Coverage in Place?	Sex (M/F)	Date of Birth *(DD/MM/YYYY)*	Age
*1			❑ Yes ❑ No			
2			❑ Yes ❑ No			
3			❑ Yes ❑ No			
4			❑ Yes ❑ No			

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

Permanent Address	City	Province	Postal Code

Permanent/Home Phone	Cell Phone
( )	( )

Email

B. School/Educational Information

Educational Institution	City	Province/State	Country

Have you received a scholarship or waiver of entrance fees?	What type?	Does it include medical coverage?
❑ Yes ❑ No		❑ Yes ❑ No

C. Coverage Selection & Payment Information

Plan Type	Coverage
❑ StudentPlan ❑ StudentPlan with Sports Coverage	❑ Single ❑ Couple ❑ Family

Start Date of Coverage *(DD/MM/YYYY)*	Expiry Date of Coverage *(DD/MM/YYYY)*	Number of Months *(must be purchased in 4-12 month increments)*

StudentPlan			
Age	Single	Couple	Family
Under 35	$50/month	$99/month	$149/month
35-54	$77/month	$153/month	$230/month

StudentPlan with Sports Coverage			
Age	Single	Couple	Family
Under 35	$105/month	$154/month	$204/month
35-54	$161/month	$238/month	$315/month

Calculate your total premium by multiplying the selected monthly premium by the number of months coverage is needed.

Rates effective June 1, 2009

Payment Calculation *(see chart above for monthly premium)*

Monthly Premium $ ____________ X Number of Months ______ = Total Premium $ ____________

Payment Method	Credit Card #	Expiry Date *(MM/YY)*
❑ Cash ❑ Cheque ❑ Visa ❑ MasterCard		

Signature of Cardholder

X

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Group Medical Services is the operating name for GMS Insurance Inc. in provinces outside of Saskatchewan.
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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.

Signature of Applicant #1	Date *(DD/MM/YYYY)*	Signature of Applicant #2 *(if applicable)*	Date *(DD/MM/YYYY)*
X		**X**	

E. For Broker/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: [ ]

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