GMS Health Benefits Claim Form:
Help us process your claim quickly

We've created this guideline to provide helpful tips for completing the GMS Health Benefit Claim form when submitting your claim. Completing the form properly ensures your claims are processed and reimbursed quickly. Don't forget, you can also **submit your claim online**. Our online claim submission form is quick, easy, and available 24/7.

IMPORTANT: Remember to attach any required physician referrals and keep a copy of the receipts for your records. Completing this claim form accurately helps us process your claims and reimburse you quickly. Feel free to contact us if you need help filling out this form.

office 306.352.7638
toll-free 1.800.667.3699
email info@gms.ca

1 If you're submitting a claim under a GMS Individual Health Plan this section must be completed by the policyholder. If you're submitting a claim under a Group Plan, the employee or group member's personal details should be provided in this section. Please ensure you have entered the current address and GMS ID number.

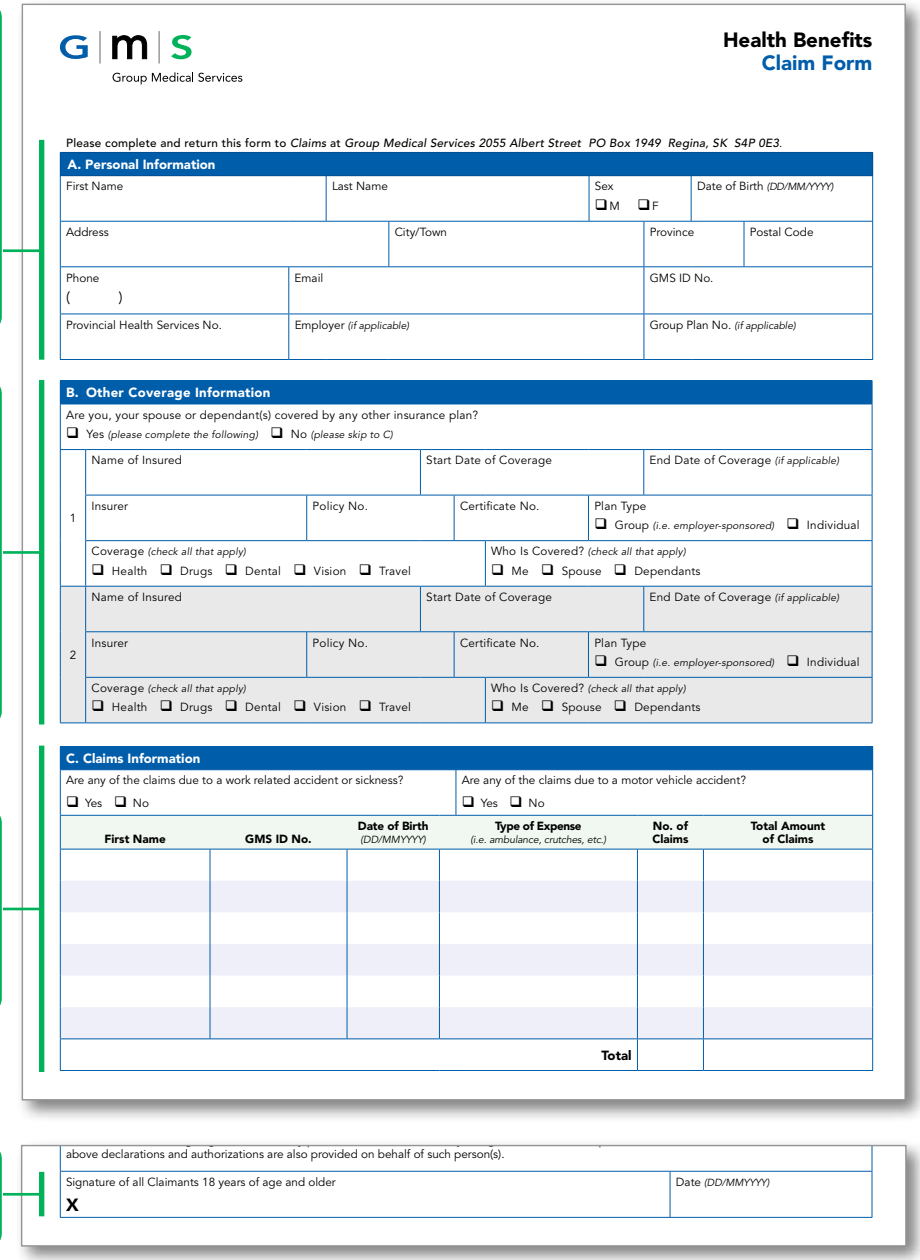
2 Complete this section in full if you or any other member of your family is entitled to benefits under another insurance plan.

Note: "Name of Insured" refers to the family member insured by another insurance provider.

"Insurer" is the name of the insurance company.

3 Check off the appropriate boxes and itemize the expenses by claimant. Provide all the information requested and remember to attach all original receipts to the claim form.

4 Sign and date the reverse side of the claim form.



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Group Medical Services

Health Benefits Claim Form

Please complete and return this form to *Claims* at *Group Medical Services 2055 Albert Street PO Box 1949 Regina, SK S4P 0E3.*

A. Personal Information

First Name	Last Name	Sex ❑M ❑F	Date of Birth *(DD/MM/YYYY)*
Address	City/Town	Province	Postal Code
Phone ( )	Email	GMS ID No.	
Provincial Health Services No.	Employer *(if applicable)*	Group Plan No. *(if applicable)*	

B. Other Coverage Information

Are you, your spouse or dependant(s) covered by any other insurance plan?
❑ Yes *(please complete the following)* ❑ No *(please skip to C)*

1	Name of Insured		Start Date of Coverage	End Date of Coverage *(if applicable)*
	Insurer	Policy No.	Certificate No.	Plan Type ❑ Group *(i.e. employer-sponsored)* ❑ Individual
	Coverage *(check all that apply)* ❑ Health ❑ Drugs ❑ Dental ❑ Vision ❑ Travel			Who Is Covered? *(check all that apply)* ❑ Me ❑ Spouse ❑ Dependants
2	Name of Insured		Start Date of Coverage	End Date of Coverage *(if applicable)*
	Insurer	Policy No.	Certificate No.	Plan Type ❑ Group *(i.e. employer-sponsored)* ❑ Individual
	Coverage *(check all that apply)* ❑ Health ❑ Drugs ❑ Dental ❑ Vision ❑ Travel			Who Is Covered? *(check all that apply)* ❑ Me ❑ Spouse ❑ Dependants

C. Claims Information

Are any of the claims due to a work related accident or sickness? ❑ Yes ❑ No	Are any of the claims due to a motor vehicle accident? ❑ Yes ❑ No

First Name	GMS ID No.	Date of Birth *(DD/MMYYYY)*	Type of Expense *(i.e. ambulance, crutches, etc.)*	No. of Claims	Total Amount of Claims
			Total		

above declarations and authorizations are also provided on behalf of such person(s).

Signature of all Claimants 18 years of age and older	Date *(DD/MMYYYY)*
X	

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HEALTH INSURANCE | TRAVEL INSURANCE | GROUP BENEFIT PLANS