GMS

GMS GROUP ADVANTAGE®
Group Insurance Application

The complete application package and first month's premium must be received at GMS head office five to seven business days before the requested effective date of this plan.

A. Applicant Information

Employer/Group Name ❑ New Application ❑ Revision to Present Plan			
Mailing Address	City	Province	Postal Code
Business Location	City	Province	Postal Code
Phone ( )	Fax ( )		
Nature of Employer's Business/Group	Date Established *(DD/MM/YYYY)*	Legal Status ❑ Corporation ❑ Partnership ❑ Proprietorship	

Group Administrator(s)

Primary	First Name	Last Name	Title
	Phone ( )	Fax ( )	Email
Secondary	First Name	Last Name	Title
	Phone ( )	Fax ( )	Email

B. Waiting Period & Number of Employees

Waiting period for new employees hired after effective date of insurance: ❑ 3 months ❑ Other *(please specify)* _____

❑ Permanent Full-time #	❑ Permanent Part-time #	❑ Contract or Seasonal #	❑ Other #

C. Selection of Coverage *(GMS Group Advantage Dental Plans must be purchased with a Group Advantage Health Plan)*

Premium Calculation: *(for GMS Group Advantage Health and Dental rates, please refer to the supplied Monthly Rates Per Employee Schedule)*

Health Coverage		
❑ Silver ❑ Gold ❑ Platinum	# of Single _____ X Rate _____	$ 0.00
	# of Family _____ X Rate _____	$ 0.00
Dental Coverage		
❑ Silver ❑ Gold ❑ Platinum	# of Single _____ X Rate _____	$ 0.00
	# of Family _____ X Rate _____	$ 0.00
	Dental Coverage Maximum ❑ $500 ❑ $1,000 ❑ $1,500 ❑ $2,000	
	Total Health and Dental	$ 0.00

Life & Disability Coverage			
Life	❑ Yes ❑ No	Monthly cost per $1,000:	$ _____
AD&D	❑ Yes ❑ No	Monthly cost per $1,000:	$ _____
Dependant Life	❑ Yes ❑ No	Monthly cost per family:	$ _____
Short Term Disability	❑ Yes ❑ No	Monthly cost per $10:	$ _____
Long Term Disability	❑ Yes ❑ No	Monthly cost per $100:	$ _____
Optional Life	❑ Yes ❑ No	Monthly cost per $1,000:	$ _____
Critical Illness	❑ Yes ❑ No	Monthly cost per $1,000:	$ _____
Dep. Critical Illness	❑ Yes ❑ No	Monthly cost per $1,000:	$ _____
Other	❑ Yes ❑ No	Monthly cost per $1,000:	$ _____
		Subtotal: Life & Disability	$ 0.00

D. Existing Coverage

Are any individuals currently receiving disability benefits under a group plan, Workers Compensation Board, or any other source?

❑ Yes ❑ No

Is this plan intended to replace any existing coverage?

❑ Yes ❑ No

E. Premium Contributions

	Employer %	Employee %		Employer %	Employee %
Extended Health Care			Dental Care		

	Employer %	Employee %		Employer %	Employee %		Employer %	Employee %
Life/AD&D			Long Term Disability			Critical Illness		
Dependant Life			Short Term Disability					

F. Payment

Total Monthly Premium

Health $ 0.00 **+ Dental** $ 0.00 **+ Life & Disability** $ 0.00 **+ PST** *(ON and SK)* $ _____ = $ 0.00
Total Monthly Premium

Choose one of the following payment options.

❑ Pre-authorized Debit *(please attach a Pre-Authorized Debit Agreement and the first month's premium)* ❑ Cheque

Requested Effective Date of this Plan:

1st day of _____ , 20_____

The complete application package and first month premium must be received at GMS Head Office 5 to 7 business days prior to the Requested Effective Date of this Plan.

G. Declaration

The applicant hereby declares that the statements and answers contained herein are full, complete and true as of the date hereof and expressly agrees that: (1) such statements and answers shall constitute the application for the contract and form part of the contract, and (2) the coverage shall become effective in accordance with and subject to the policy to be issued to the applicant but in no case shall it become effective until this application has been approved by Group Medical Services (GMS). GMS will not be liable to the applicant or any of the applicant's employees until the application is approved. The applicant understands that Life, AD&D, Dependant Life, Long Term Disability, Short Term Disability and Critical Illness are provided by Assumption Life and that GMS acts only as the administrative agent for Assumption Life in placing and administering such coverage. Assumption Life and not GMS has the authority and responsibility for assessing and approving your application for such coverage and any claims made thereunder. As such, any policy providing such coverage, if approved by Assumption Life, will be a contract with Assumption Life and the information you have supplied in this application will be provided to and relied on by Assumption Life and included as part of that contract. The undersigned declares that he/she has authority to sign on behalf of the applicant and understands that, whether before or after the date of application, any misrepresentation, incorrect or concealed information or failure to fully complete all sections of the application may void coverage.

Do not terminate any existing coverage until notice has been given in writing that the coverage being applied for is approved by GMS.

Dated at_____ this_____ day of_____ , _____ .

by _____ _____

Applicant Signature *Please print name and title*

Office Use Only: Date Received: Group #: RSL: Agent #: