GMS

GROUP BENEFIT PLANS
Application

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	Date Established *(DD/MM/YYYY)*

Legal Status

❑ Corporation ❑ Partnership ❑ Proprietorship ❑ Association ❑ Other *(please indicate)* _____

Full names of Branch Affiliates or Subsidiaries *(list all that are to be included all under one monthly invoice)*

Affiliated	Subsidiary	Name and Address	# of Employees
❑	❑		
❑	❑		

Group Administrator(s)

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

B. Selection of Coverage, Monthly Premium Calculation

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 #

Health & Dental Coverage		
Custom Health	# of Single _____ X Rate _____	$ _____
	# of Family _____ X Rate _____	$ _____
Custom Dental	# of Single _____ X Rate _____	$ _____
	# of Family _____ X Rate _____	$ _____
	Subtotal: Health & Dental	$ _____

Please attach a copy of the accepted proposal, indicating chosen benefit plans.

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:	$ _____
Critical Illness	❑ Yes ❑ No	*Cost incorporated with Long Term Disability*	
Optional Life	❑ Yes ❑ No	Monthly cost per $1,000:	$ _____
		Subtotal: Life & Disability	$ _____

Total Monthly Premium: (Health & Dental $ _____ **+ Life & Disability $** _____**) + PST** *(Ontario Only)* **$** _____ **= $**

Total Monthly Premium

Office Use Only: Date Received: DD / MM / YYYY BDC: Agent #1: Agent #2: Split: A1% / A2%

C. Payment Options

Choose one of the following payment options

❑ Pre-authorized Debit *(please attach a Pre-Authorized Debit Agreement)* ❑ Cheque

Requested Effective Date of this Plan:

1st day of _____ , 20_____

D. Additional Information

Are any employees or dependants currently hospital confined or otherwise disabled or handicapped?

❑ Yes ❑ No

Is this plan to be in addition to any other group life and/or health plan presently in force?

❑ Yes ❑ No

Is this plan intended to replace any existing coverage?

❑ Yes ❑ No *If Yes, please complete the following section.*

Benefit	Name of Current Carrier	Effective Date of Present Coverage *(DD/MM/YYYY)*
Extended Health Care		
Dental Care		
Life		
AD & D		
Optional Life		
Optional AD & D		
Dependant Life		
Short Term Disability		
Long Term Disability		

Premium Contributions:

	Employer %	Employee %		Employer %	Employee %
Extended Health Care			Dependant Life		
Dental Care			Short Term Disability		
Life/AD & D			Long Term Disability		

G. Declaration

The applicant hereby declares that, to the best of the applicant's knowledge, 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 to any of the applicant's employees until the application is approved. The applicant understands that the Life, AD&D, Dependent Life, Short Term Disability and Long Term Disability are provided by The Wawanesa Life Insurance Company ("Wawanesa Life") and that GMS acts only as the administrative agent for Wawanesa Life in placing and administering such coverage. Wawanesa 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 Wawanesa Life, will be a contract with Wawanesa Life and the information you have supplied in this application will be provided to and relied on by Wawanesa Life and included as part of that contract. The undersigned understands that he/she has the 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 the 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*