GMS

GROUP BENEFIT PLAN
Enrolment/Change Form

Please be sure to complete all sections of this form, then return it to your Plan Administrator.

A. General Information *(to be completed by Plan Administrator)*

❑ New Employee/Member ❑ Re-hire ❑ Termination ❑ Changing Information

If changing information, reason for change:

Employer/Group Legal Name	Operating Name *(complete if different from legal name)*		
Employee/Member Occupation	Class	Regular Hrs/Wk	Annual Earnings
Permanent Full-Time Hire Date *(DD/MM/YYYY)*	Coverage/Change/Termination Effective Date *(DD/MM/YYYY)*		
Re-hire *(If re-hire is within six months, coverage will be effective as of the re-hire date; otherwise the waiting period must be served.)*			
Date Previous Employment Ended *(DD/MM/YYYY)*	Re-hire Date *(DD/MM/YYYY)*		
Signature of Plan Administrator **X**		Date *(DD/MM/YYYY)*	

B. Employee/Member Information - Initial Application or Changing Information *(to be completed by the employee/member)*

First Name	Last Name	Sex ❑ M ❑ F	Date of Birth *(DD/MM/YYYY)*
Address	City	Province	Postal Code
Phone ( )	Email	Provincial Health Care Coverage in Place? ❑ Yes ❑ No	

C. Family Information - Initial Application or Changing Information *(to be completed by the employee/member)*

	First Name	Last *(if different from yours)*	Sex	Date of Birth *(DD/MM/YYYY)*	Provincial Health Care Coverage in Place?	Dependant age 21 or over?[2]
Spouse[1]			❑ M ❑ F		❑ Yes ❑ No	N/A
Dependant			❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No
Dependant			❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No
Dependant			❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No

[1] If your spouse is common-law, please complete the following:
I have been living with and representing the above as my spouse since
DD/MM/YYYY
My common-law spouse and I are financially responsible for all our dependants claimed for insurance purposes.

[2] For each dependant age 21 and over:
- in the case of a student dependant under age 25, please complete the over-age dependant questionnaire available at www.gms.ca.
- in the case of a dependant due to a developmental or physical disability, please attach or enclose a doctor's note or copy of an equivalent document as evidence.

D. Other Insurance Coverage *(only include personal or group plans that will continue to be in effect at the same time as the GMS health plan)*

Do any listed Applicants have additional coverage with another insurer? ❑ Yes ❑ No *If "Yes", please complete the section below.*

Insurance Company Name	Name of Insured Person	Policy/Certificate #	Persons Covered Under Plan	Coverage *(check all that apply)* ❑ Personal Plan ❑ Group Plan
			❑ Applicant ❑ Spouse ❑ Dependant	❑ Health ❑ Drug ❑ Vision ❑ Dental ❑ Travel
			❑ Applicant ❑ Spouse ❑ Dependant	❑ Health ❑ Drug ❑ Vision ❑ Dental ❑ Travel

Office Use Only: GMS ID# Group # Coverage Effective Date

E. Waiving Benefits *(complete this section to waive benefits if you and your spouse/dependants have coverage under your spouse's plan)*

- ❑ Waive Health for myself and spouse/dependant(s)
- ❑ Waive Health for my spouse/dependant(s) ONLY
- ❑ Waive Dental for myself and spouse/dependant(s)
- ❑ Waive Dental for my spouse/dependant(s) ONLY

Spouse's Insurance Carrier	Plan/Policy Number

Employee Signature	Date *(DD/MM/YYYY)*
X	

NOTE: *If you or your spouse/dependant(s) lose coverage under your spouse's plan, you can enrol in this plan. To enrol, you must complete and submit an enrolment form within 31 days of losing coverage. If you apply after 31 days, you may be required to complete a medical questionnaire to qualify for coverage.*

F. Life Insurance Beneficiary Designation *(complete this section if this group benefit plan includes coverage for Life Insurance)*

Beneficiary First Name	Beneficiary Last Name	Date of Birth *(DD/MM/YYYY)*	% Share		Relationship
				❑ Revocable ❑ Irrevocable	
				❑ Revocable ❑ Irrevocable	
				❑ Revocable ❑ Irrevocable	
				❑ Revocable ❑ Irrevocable	

If the designated beneficiary is a minor, I appoint the following person as trustee.	Relationship

NOTE: *Unless otherwise stipulated or not permitted by law, any beneficiary designation is revocable. If a beneficiary is named irrevocably, please note that his/her consent is required for any request that may affect his/her rights, including a change of beneficiary.*

Complete the following if you are making a change to an Irrevocable Beneficiary. *(The effective date of the beneficiary change will be the date this form is signed.)*

Signature of Previous Irrevocable Beneficiary	Print Name of Previous Irrevocable Beneficiary	Date *(DD/MM/YYYY)*
X		

G. 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 their designated travel assistance representative(s) (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.

GMS may, for the purposes of administering any benefits, products or services to be provided pursuant to this policy, for the purposes set out in the GMS privacy statement and for the purposes of determining eligibility for benefits: (a) collect, store and use any personal information about you, which you have provided to GMS, or any personal information which GMS has obtained pursuant to clause (b); and/or (b) obtain personal information about you from, or disclose such personal information to: any Government Plan; the operator of any hospital, clinic, or other health facility; a physician 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 in (a) 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) and confirm that each of the above declarations and authorizations are also provided on behalf of such person(s).

I understand that the Life, AD&D, Dependant Life, Short Term Disability, Long Term Disability, and Critical Illness benefits 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.

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 co-ordinate any eligible expenses with any additional insurer that I or any person herein listed may have coverage under.

Employee/Member Signature	Date *(DD/MM/YYYY)*
X	

To avoid delays in processing, make sure all sections of this form are completed in full. When completed, return to your Plan Administrator.