



## ASSIGNMENT OF INFORMATION Insurance Benefit/Premium Refund

Please complete this form and submit with your claim form or written request for a refund.  
Please note this assignment of payment will not be retained for future transactions, and will only be applied to the claim or refund request to which it is attached.

A. Personal Information			
First Name		Last Name	
Address		City	Province
		Postal Code	
Phone (     )	Email		GMS Policy #

B. Assignment Details			
If assigning to an individual, please provide the first and last name to be shown on the payment to be assigned.			
First Name		Last Name	
		Date of Birth (DD/MM/YYYY)	
Address		City	Province
		Postal Code	
Phone (     )	Email		
If assigning to a broker or agency, please give the name of the brokerage to be shown on the payment to be assigned.			
Agency Name			
Agency Address		City	Province
		Postal Code	
I am authorizing Group Medical Services to make the following payable to the above noted individual or brokerage:			
<input type="checkbox"/> Premium Refund <input type="checkbox"/> Insurance Benefit Payment			

C. Authorization of Premium Refund/Assignment Insurance Benefit Payment		
<p>I /We direct and authorize any applicable (<i>please select one</i>) <input type="checkbox"/> Premium Refund    <input type="checkbox"/> Insurance Benefit Payment, subject to any policy terms and conditions, be made payable to the company or individual(s) as indicated in section B above. I/We understand that this authorization overrides any other provisions for payment which may be set out in the policy wording.</p> <p>I agree that this authorization directs Group Medical Services ("GMS") to pay any amount to which I may become entitled to my assignee. Once GMS has paid my assignee pursuant to this authorization I agree that I will not be entitled to demand payment for those amounts paid to my assignee from GMS.</p> <p>A photocopy, fax or scan of this authorization shall be considered as effective and valid as the original. I agree that this authorization expires one year from the date written below.</p> <p>I agree that my electronic signature in this agreement has the same legal effect as handwritten signatures. Electronic signatures include any information in electronic form that a party has created or adopted in order to sign a document and that is in, attached to, or associated with the document, including signatures sent by fax or email.</p>		
Signature of Policyholder/Guardian/Executor <b>X</b>	Policyholder ( <i>please print full name</i> )	Date (DD/MM/YYYY)

*Please submit your form to Group Medical Services, 2055 Albert Street, PO Box 1949 Regina, SK, S4P 0E3  
or scan and email to [info@gms.ca](mailto:info@gms.ca).*