Group Medical Services

Information Update Form

Please complete all sections and submit to Claims at *Group Medical Services 2055 Albert Street PO Box 1949 Regina, SK S4P 0E3*

A. Personal Information

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

B. Family Information

	First Name	**Last** *(if different from yours)*	**Sex**	**Date of Birth** *(DD/MM/YYYY)*	**Provincial Health Care Coverage in Place?**	**Disabled Dependant?**
Spouse			❑ 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
Dependant			❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No
Dependant			❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No

Are any of the dependants listed above students under age 25?

❑ Yes ❑ No *If "Yes", please list:*

C. 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 D)*

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	

continued...

D. Declaration

I/We ("I") declare the statements made herein are true and complete. For the purposes of administering any Group Medical Services ("GMS") benefits, products or services (collectively "benefits") and/or determining eligibility for benefits, I authorize GMS to: (a) collect, store and use any personal information which I have provided to GMS or personal information obtained pursuant to clause (b); and/or (b) obtain personal information about me (or any other person listed herein) from, or disclose such personal information to: my Government Health Insurance Plan; the operator of any hospital, clinic, or other health facility; a doctor 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 above.

I understand that any misrepresentation, incorrect or concealed information may void my coverage. I declare that, if I am signing on behalf of any person(s) listed herein, I have the authority to sign on behalf of such person(s) listed herein and confirm that each of the above declarations and authorizations are also provided on behalf of such person(s).

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

Signature **X**	Date *(DD/MM/YYYY)*
Signature of Spouse **X**	Date *(DD/MM/YYYY)*
Signature(s) of Dependent Children 18 & Older **X**	Date *(DD/MM/YYYY)*

Group Medical Services respects your privacy. We will not disclose your personal information, except as detailed above, without your written consent. The Consent to Disclose Personal Information Form is available at gms.ca.