HOSPITAL CASH
Claim Form

INSTRUCTIONS

1. Complete all sections in full and attach the following documents: Official discharge papers from the hospital stating the admission and discharge dates.
2. Sign and date the completed form, and send package to: Group Medical Services, Attn: Claims, 2055 Albert Street, PO Box 1949 Regina, SK, S4P 0E3

A. Policyholder Information

First Name	Last Name	Sex ❑ M ❑ F	Date of Birth *(DD/MM/YYYY)*

Address	City/Town	Province	Postal Code

Phone ( )	Email	GMS ID No.

B. Other Coverage Information

Do you, your spouse, or any dependant(s) have Hosptial Cash or equivalent coverage under any other insurance plan?

❑ Yes *(please complete the table below)* ❑ No *(please proceed to Section C.)*

Name of the Insured	State Date of Coverage *(DD/MM/YYYY)*	Insurer	Policy Number	Certifificate Number	Who is Covered? *(check all that apply)*
					❑ Me ❑ My Spouse ❑ My Dependants

C. Claim Information

Claimant's First and Last Name *(if not the policyholder)*	Date of Birth *(DD/MM/YYYY)*	GMS ID No.

What was the diagnosis of illness/injury that resulted in a hospital stay?	Date Illness/Injury Began *(DD/MM/YYYY)*

If the claim is the result of an injury, describe how the injury occured.	Date of Incident *(DD/MM/YYYY)*

Date You Were Awaiting, Wait Listed or Scheduled for Hospitalization or Surgery *(DD/MM/YYYY)*	If Cancer Related, Original Date Diagnosed with Cancer *(DD/MM/YYYY)*

If the hospital stay was pregancy related, what is the expected date of delivery *(DD/MM/YYYY)*?

Physician Name & Specialty	Address	Phone
		( )
		( )
		( )

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 warrant that neither I nor any person herein listed have any additional coverage through any insurer other than the information listed herein and hereby authorize GMS to coordinate any eligible expenses with any additional insurer listed herein. I understand that any misrepresentation, incorrect or concealed information or failure to fully complete all sections of this form 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) listed herein and confirm that each of the above declarations and authorizations are also provided on behalf of such person(s).

Signature of Claimant *(or signature of Policyholder if Claimant is under 18 years of age)*	Date *(DD/MM/YYYY)*
X	