GMS Group Medical Services

Group Benefit Plans
Employee Enrolment / Change Form

Please complete and return this form to your Group Benefit Plan Administrator.

A. General Information *(To be completed by the employer)*

Company ______________________________

Employee/Member Occupation ______________ Class ________ Regular hrs/week ____ Annual Earnings ________

☐ New Employee ☐ Re-hire ☐ Termination ☐ Changing Information Reason for Change ______________

Permanent full-time hire date DD / MM / YYYY Coverage/Change/Termination Effective Date DD / MM / YYYY

If a re-hire[1], provide the date previous employment ended DD / MM / YYYY and re-hire date DD / MM / YYYY

[1] *If re-hire is within 6 months, coverage will be effective as of the rehire date; otherwise, the waiting period must be served.*

Signature of Plan Administrator X ______________________________ **Date** DD / MM / YYYY

B. Plan Member/Employee Information *(To be completed by the employee)*

Employee Name ______________________________ Tel. Number ( ) ____________

Address ______________________ City ______________ Province ________ Postal Code ________

C. Applicant/Family Information – Initial Application or Changing Information *(To be completed by single applicants and applicants with families)*

	Surname	Given Name(s)	Date of Birth	Sex	Provincial Health Care Coverage in Place?	Dependant Child over the age of 21? [2]	Are you, your spouse and/or children covered by any other insurance plan? *(Indicate Name of Carrier)* Health	Dental
Employee			DD / MM / YYYY	M/F	☐ Yes ☐ No	n/a	☐ Yes ☐ No	☐ Yes ☐ No
Spouse [1]			DD / MM / YYYY	M/F	☐ Yes ☐ No	n/a	☐ Yes ☐ No	☐ Yes ☐ No
Child			DD / MM / YYYY	M/F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Child			DD / MM / YYYY	M/F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Child			DD / MM / YYYY	M/F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Child			DD / MM / YYYY	M/F	☐ Yes ☐ No	☐ Yes ☐ No	☐ 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 of our children claimed for insurance purposes. I further verify that I am not obliged to provide coverage for my legal spouse.

[2] For each Dependant Child age 21 and over:

- For a Student Dependant under age 25, indicate the educational institution where the child is receiving full-time training: ______________
- In the case of Dependant due to a developmental or physical disability, please attach or enclose a doctor's note or copy of an equivalent document as evidence.

For Office Use Only: GMS ID#: ________ Group #: ________ Coverage Effective Date: DD / MM / YYYY

D. Refusal of Benefits *(Complete this section if you wish to refuse enrolment in this group benefit plan)*

I have been given the opportunity to apply for coverage but do not wish to participate, as I have coverage under my spouse's plan. I understand that I will not be able to enroll in these plans at a later date without the mutual consent of my employer and Group Medical Services.

❑ Waive Health ❑ Waive Dental ❑ Waive both Health and Dental

Signature X _____ **Date** DD / MM / YYYY

Employee/Plan Member Signature

E. 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.

For the purposes of administering any GMS benefits, products or services (collectively "benefits") and/or determining eligibility for benefits, I authorize GMS to: (a) collect, store and use any information which I have provided or information obtained pursuant to clause (b); and/or (b) obtain information from, or disclose 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.

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 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.

Signature X _____ **Date** DD / MM / YYYY

Employee/Plan Member Signature

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