Group Medical Services

TravelStar® Emergency Medical
(Single Trip Daily)
Group Application

Group Single Trip Daily Emergency Medical coverage is applicable for groups of five or more people traveling for 21 days or less.
Any group member 60 years of age or older must also complete and attach a TravelStar Travel Insurance Application to determine their daily rate.

A. Applicant Information

Group Name	Group Type *(team, organization, school, etc.)*	TC	
Group Contact Name			
Address	City	Province	Postal Code
Phone *(Would you like GMS to call and confirm coverage is in effect?* ❑ *Yes* ❑ *No)* ( )	Email		

B. Travel Information

Departure Date *(DD/MM/YYYY)*	Return Date *(DD/MM/YYYY)*	Number of Days	Destination

C. Premium Calculation

Age	Medical Questionnaire Required?	Number of Insured Persons	Number of Days	Daily Rate *(Please choose one deductible)* ❑ $250 Deductible	Daily Rate ❑ $0 Deductible	Premium *(Number of Insured Persons x Number of Days x Daily Rate)*
Under 18	No			$1.15	$1.27	
18 - 34	No			$1.30	$1.43	
35 - 54	No			$1.53	$1.68	
55 - 59	No			$2.25	$2.48	
60 - 64	Yes*					
65 - 69	Yes*					
					Total Premium†	$

**Requires completion of a standard TravelStar medical questionnaire for each insured person.*
†A minimum premium of $15 will apply

D. Payment

Please select your payment method:
❑ Cheque ❑ Visa ❑ MasterCard

Cardholder Name	Credit Card Number	Expiry Date

Signature
X

Coverage will be effective upon Group Medical Services approval of the application and receipt of the appropriate premium. If an adjustment has been made to your policy and you are not fully satisfied, you will have seven days from confirmation to obtain a refund, provided you have not travelled under this policy.

Continued...

E. Group Members

Please list Group Members *(attach a separate list if required).*

First Name	Last Name	Province of Residence	Date of Birth *(DD/MM/YYYY)*	Age
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35.				

F. Eligibility *(ALL Group Members must answer NO to the following questions)*

1. Are *you* awaiting further tests or treatment for heart disease or have you ever been diagnosed with congestive heart failure (CHF)?
2. Do *you* have both heart disease and insulin dependent diabetes and take prescription medication for both?
3. Do *you* use home oxygen for a heart and/or lung disease?
4. Do *you* take oral steroids for a lung condition?
5. Do any of the following apply to you:
   - *a) you* are under active treatment for cancer or have metastatic cancer; or
   - *b) you* have an aortic or intracranial aneurysm that remains surgically untreated; or
   - *c) you* have experienced undiagnosed episodes of syncope/fainting or falling?
6. Do you have an ICD (Implantable Cardioverter Defibrillator)?
7. In the past twelve (12) months:
   a) Have *you* suffered from, been diagnosed with, received new treatment for, or had a recurrence of, or complications relating to any of the following?

stroke/TIA	blood clots	atrial flutter	atrial/ventricular fibrillation	peripheral vascular disease
AIDS	any terminal illness	renal/liver failure	gastrointestinal bleeding	

   b) Have *you* undergone the following procedures?

renal dialysis	valve replacement	valve surgery	organ transplant

you is any person who is eligible for coverage under any benefit of this policy

Each Group Member must answer NO to ALL of the above questions and have provincial health coverage in place, in order to be eligible to purchase this plan.

I hereby warrant that everyone listed on this application is eligible for coverage under this plan: ❑ Yes

TravelStar® benefits, eligibility criteria, including the 180 day stability clause, Exclusions and Specific Conditions apply. Please refer to the TravelStar policy wording for eligibility details.

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 its authorized agents, representatives, affiliates or other service providers (collectively "GMS") any information concerning 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 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, 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) listed herein and confirm that each of the above declarations and authorizations are also provided on behalf of such person(s).

Should I, or any person herein listed, currently have or subsequently obtain additional coverage through any insurer, while covered under this contract, I will advise GMS at the time notice of claim is made. I hereby authorize GMS to coordinate any eligible expenses with any additional insurer that I, or any person herein listed, may have coverage under. Should I fail to disclose other insurance at the time of notice of claim, I agree to reimburse GMS any expenses that it would otherwise not have incurred as a result of the non-disclosure.

Signature of Applicant/Group Contact	Date *(DD/MM/YYYY)*
X	

H. For Agent Use Only

The undersigned hereby confirms that appropriate disclosure, as set out in the Canadian Council of Insurance Regulators: Advisor Disclosure document, has been made to the client regarding: (a) the company or companies represented; (b) that a commission is received for sale of this insurance product; (c) that additional compensation may be received in the form of bonuses; (d) any conflict of interest with respect to this transaction.

Agent Signature

X

Agent #1	Agent #2	Split	For Office Use Only: Effective Date	GMS #