REPLACEMENT HEALTH COVERAGE
Application

BROKER/AGENT: Please complete the designated section at the end of this application to confirm proper disclosure has been made to the client.

A. Applicant Information

Address	City	Province	Postal Code

Phone ( )	Email	
		❑ *Yes, I would like to receive email about special offers, promotions and opportunities to provide feedback about GMS products and services.*

Persons to be Insured† *(collectively referred to as Applicants)*	**First Name**	**Last Name**	**Provincial Health Care Coverage in Place?**	**Gender** *(M/F)*	**Date of Birth** *(DD/MM/YYYY)*	**Student***
1. Applicant			❑ Yes ❑ No			N/A
2. Spouse/ Common Law			❑ Yes ❑ No			N/A
3. Dependant			❑ Yes ❑ No			❑
4. Dependant			❑ Yes ❑ No			❑
5. Dependant			❑ Yes ❑ No			❑
6. Dependant			❑ Yes ❑ No			❑

†*Families with more than six people – please list the additional people on a separate sheet of paper and attach it to this application.*
**Students between the age of 21 and 24 must be attending a full-time educational training program in Canada. Verification of over-age dependants will be requested annually. For permanently disabled dependants over the age of 20, medical verification will be requested.*

B. Details of Group Plan Being Replaced

Note: To qualify for GMS Replacement Health Coverage, the effective date of this plan must be no later than 90 days from the date on which the applicant's prior coverage ended.

Name of Insurance Company	Name of Employer

Employer Contact/Plan Administrator	Employer Phone

Policy Number	Group/Certificate Number

Effective Date of Coverage *(DD/MM/YYYY)*	Expiry Date of Coverage *(DD/MM/YYYY)*	Benefits Provided under Prior Plan
		❑ Health ❑ Vision ❑ Prescription Drug ❑ Travel ❑ Dental

❑ I understand that to be eligible for GMS Replacement Health Coverage the effective date chosen must be within 90 days of when my current group benefit plan expires/expired and I must have and maintain valid government health insurance in the province in which I reside. For a plan to be an eligible group plan, it must be partially or fully paid for by your employer. GMS reserves the right to verify the information provided. Coverage will be void if I do not meet the eligibility requirements.

C. Coverage Selection

Note: Your plan type cannot be upgraded at a later date. You can downgrade at renewal.

Family Status	Select Plan Type
❑ Single (1 person) ❑ Couple (2 people) ❑ Family (3+ people)	❑ PremierPlan ❑ ChoicePlan ❑ EssentialPlan

I would like my coverage to be effective on: *(DD/MM/YYYY)*

D. Other Insurance Coverage

(only include personal or group plans that will continue to be in effect at the same time as the GMS health plan)

Does anyone on the application have additional coverage with GMS or another insurer? ❑ Yes ❑ No

Insurance Company Name	Name of Policyholder	Persons Covered under Plan	Coverage Type *(check all that apply)*	Plan Type
		❑ Applicant ❑ Spouse ❑ Dependant	❑ Health ❑ Drug ❑ Vision ❑ Dental ❑ Travel	❑ Group ❑ Individual
		❑ Applicant ❑ Spouse ❑ Dependant	❑ Health ❑ Drug ❑ Vision ❑ Dental ❑ Travel	❑ Group ❑ Individual

E. Rate

Monthly Premium *(view the rate schedule for your province at gms.ca)* **TOTAL $**

When determining your monthly rate

- Depending on your province of residence the premium charged may be subject to tax;
- Family means three or more;
- for Couple or Family, the oldest person on the application determines the rate; and
- a 30% surcharge will apply to all plans with more than six individuals to be insured.

Coverage will be governed by the terms and conditions described in the policy available at www.gms.ca. A copy of the policy will be sent to you upon receipt of your application by GMS.

F. Method of Payment *(select annual or monthly payment option)*

❑ **Annual Payment**

Annual Premium

$ ❑ Cash ❑ Cheque ❑ Visa ❑ MasterCard

Credit Card Number	Expiry Date *(MM/YY)*	Signature of Cardholder
		X

❑ **Monthly Payment Plan Through Pre-Authorized Debit (PAD)** *(please provide your account information on the following page)*

Your first month's payment must be made separately by one of the options below. Your bank account will **not** be debited for your first month's payment.

How would you like to make your first month's payment? ❑ Cheque ❑ Cash ❑ Visa ❑ MasterCard *(Please do not send cash in the mail)*

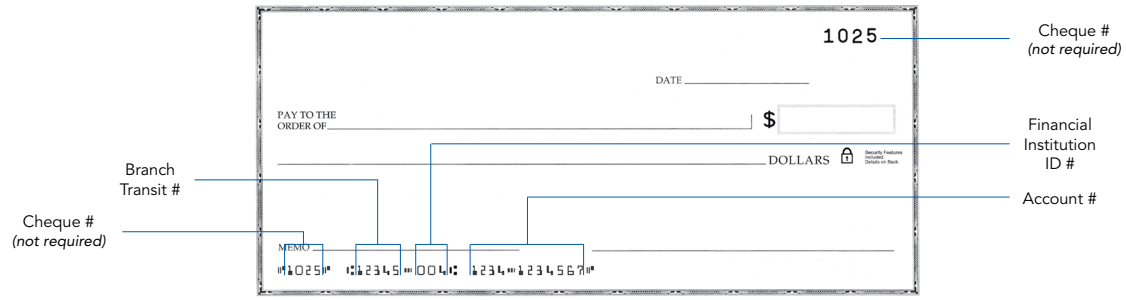
Credit Card Number *(if different than above)*	Expiry Date *(MM/YY)*	Signature of Cardholder
		X

Account Information for ongoing monthly payments *(please include a void cheque or complete banking information below)*

First Name of Account Holder *(if different than applicant)*	Last Name of Account Holder *(if different than applicant)*
Monthly Premium Amount $	Monthly Withdrawal Date ❑ 1st of the month ❑ 15th of the month

Financial Institution ID Number	Branch Transit Number	Account Number
☐☐☐	☐☐☐☐☐	☐☐☐☐☐☐☐☐☐☐☐☐

Is this a change to your PAD Agreement information? *If "Yes", please describe the reason for change.* ❑ Yes ❑ No



Pre-Authorized Debit (PAD) Agreement

I/We ('I") authorize Group Medical Services (GMS), and the financial institution being designated to begin deductions as per my/our ("my") instruction for monthly regular recurring payments, and/or one-time payments from time to time, for payment of all charges arising under my GMS account(s).

This Pre-Authorized Debit (PAD) agreement may be cancelled at any time provided notice is received in writing, at the address provided at least 10 business days before the next withdrawal is scheduled to be processed. Please contact our office or visit our website to obtain a cancellation form.

I have certain recourse rights if any withdrawal does not comply with this agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

The following terms and conditions apply to the processing of a PAD withdrawal.

- For health plans, an administration fee of $1 per month is applied to the amount owed when payment is made using PAD and will be applied to your monthly withdrawal.
- Non-Sufficient Fund (NSF) withdrawals will be handled in accordance with GMS' standard NSF policy and in accordance with the rules laid out by The Canadian Payments Association (CPA).
- Information on the administration fees and GMS' standard NSF policy can be found at gms.ca
- Withdrawal payments will continue until such time as written notice to the contrary is given, in accordance to the right of termination outlined in this PAD Agreement. Any outstanding premium must be paid in full at such time to ensure continued coverage of the product/service payment was being applied to.
- Where a one-time payment is to be processed, funds will be withdrawn on my regular withdrawal date in the month following the service delivered.
- Any change to the information provided under this PAD Agreement or to the product or service for which this PAD Agreement is attached, will require that a new PAD Agreement be completed, signed and submitted to GMS Head Office along with a void cheque. We require receipt of this new PAD Agreement at least 10 business days before the next debit is scheduled to process.

I agree to and understand the terms and conditions set forth and ask that funds begin to be withdrawn from my account as indicated.

Signature of Authorized Account Holder*	Signature of Authorized Account Holder*
X	**X**
Name *(please print)*	Name *(please print)*

** Where Account Holder's account agreement requires the signature of two or more signing authorities, the signatures of all such persons are required for the purposes of this Pre-Authorized Debit Agreement.*

G. Applicant 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 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 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 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).

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.

Applicant's Signature	Date *(DD/MM/YYYY)*
X	

Before you submit your application

Please make sure you've:

- ☑ **selected your plan effective date**
- ☑ **signed and dated your application**
- ☑ **if paying monthly by PAD, enclosed a cheque for your first month's payment or provided your banking information for**

For broker or 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 Robert Bozzo Agent #2 _____ Split A1% / A2% For office use: Effective Date: DD/MM/YYYY GMS ID: 488135