

The application package (application, enrolment forms and PAD agreement) and a cheque for first month's premium must be received at GMS head office ten business days before the requested effective date of this plan. Please make sure information is complete and accurate to avoid delaying the effective date.

**Enrollment Requirements:**

- A business must be in operation for a minimum of 6 months for Health & Dental benefits and 12 months for Life benefits.
- Trucking and Real Estate businesses as well as Not-for-Profit organizations will require pre-approval from GMS.
- An employee must work a minimum of 20 hours per week to be considered "actively at work" and eligible for coverage.
- A minimum of 3 eligible employees is required to maintain a plan.
- All eligible employees must participate in the plan except with evidence they are covered under their spouse's group plan.

A. Applicant Information			
Employer/Group Legal Name	<input type="checkbox"/> New Application <input type="checkbox"/> Revision to Plan	Operating Name (complete if different from legal name)	
Mailing Address	City	Province	Postal Code
Business Location	City	Province	Postal Code
Phone ( )	Fax ( )		
Nature of Employer's Business			Date Established (DD/MM/YYYY)
Legal Status			
<input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Association <input type="checkbox"/> Other (please indicate) _____			

**Full names of Branch Affiliates or Subsidiaries** (list all that are to be included under one monthly invoice)

Affiliated	Subsidiary	Name and Address	# of Employees
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		

Group Administrator(s)			
Primary	First Name		Last Name
	Phone ( )	Fax ( )	Email
Secondary	First Name		Last Name
	Phone ( )	Fax ( )	Email

**B. Waiting Period & Number of Employees**

The waiting period for new employees hired after effective date of this plan is 3 months unless otherwise specified: \_\_\_\_\_ month(s)

<input type="checkbox"/> Permanent Full-time #	<input type="checkbox"/> Permanent Part-time #	<input type="checkbox"/> Contract or Seasonal #
--	--	---

### C. Class Selection

How many classes of employees will be eligible for benefits? (minimum of 3 lives is required for 2 classes)

Single Class (all employees are Class A)

Multiple Classes (examples of classes could be Owners, Managers, All other employees)

Class A classifications: \_\_\_\_\_ Class B classifications: \_\_\_\_\_

### D. Selection of Coverage

#### Health & Dental Coverage

	Class A	Class B
<b>Health</b>	# of singles _____ # of families _____ <input type="checkbox"/> Silver <input type="checkbox"/> Gold <input type="checkbox"/> Platinum	# of singles _____ # of families _____ <input type="checkbox"/> Silver <input type="checkbox"/> Gold <input type="checkbox"/> Platinum
<b>Dental</b>	# of singles _____ # of families _____ <input type="checkbox"/> Silver <input type="checkbox"/> Gold <input type="checkbox"/> Platinum Coverage Maximum: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	# of singles _____ # of families _____ <input type="checkbox"/> Silver <input type="checkbox"/> Gold <input type="checkbox"/> Platinum Coverage Maximum: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000
<b>Health Care Spending Account</b>	# of employees _____ <input type="checkbox"/> No carry forward <input type="checkbox"/> Carry forward Allotment Amount _____ (min of \$250 to max of \$15,000 increased by \$50 increments)	# of employees _____ <input type="checkbox"/> No carry forward <input type="checkbox"/> Carry forward Allotment Amount _____ (min of \$250 to max of \$15,000 increased by \$50 increments)

#### Group Advantage Plus Life & Disability Coverage

	Class A	Class B
<b>Life + AD&amp;D</b>	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> 1xAnnual Salary	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> 1xAnnual Salary
<b>Dependent Life</b>	<input type="checkbox"/> \$5,000 (spouse) / \$2,500 (dependents) of coverage <input type="checkbox"/> \$10,000 (spouse) / \$5,000 (dependents) of coverage	<input type="checkbox"/> \$5,000 (spouse) / \$2,500 (dependents) of coverage <input type="checkbox"/> \$10,000 (spouse) / \$5,000 (dependents) of coverage
<b>Traditional Critical Illness or High Severity Critical Illness</b>	<input type="checkbox"/> <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 (Available to groups of 6 -10) <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 (Available to groups of 6 -10) <input type="checkbox"/>
<b>*Dependent Critical Illness (Same as above)</b>	<input type="checkbox"/> \$5,000 (spouse) / \$2,500 (dependents) of coverage <input type="checkbox"/> \$10,000 (spouse) / \$5,000 (dependents) of coverage	<input type="checkbox"/> \$5,000 (spouse) / \$2,500 (dependents) of coverage <input type="checkbox"/> \$10,000 (spouse) / \$5,000 (dependents) of coverage
<b>Short Term Disability</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Long Term Disability</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Second Medical Opinion</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

\*For Dependent Critical Illness, High Severity Critical Illness is only applicable to the Employee and Spouse and not to Dependent Children.

### D. Existing Coverage

Are any individuals currently receiving disability benefits under a group plan, Workers Compensation Board, or any other sources?

Yes  No

Is this plan intended to replace any existing coverage?

Yes  No

E. Premium Contributions				
	Class A		Class B	
	Employer %	Employee %	Employer %	Employee %
Health	%	%	%	%
Dental	%	%	%	%
Life + AD&D	%	%	%	%
Dependent Life	%	%	%	%
Traditional Critical Illness or High Severity Critical Illness	%	%	%	%
Dependent Critical Illness <i>(Traditional or High Severity Critical Illness required)</i>	%	%	%	%
Short Term Disability	%	%	%	%
Long Term Disability	%	%	%	%
Second Medical Opinion	%	%	%	%

If optional coverage for life or critical illness is selected, premiums are 100% employee paid.

F. Payment									
<b>Total Monthly Premium</b>									
Health	\$ _____	+ Dental	\$ _____	+ Group Advantage Plus	\$ _____	+ PST	\$ _____	= \$ _____	Total Monthly Premium
Choose one of the following payment options.									
<input type="checkbox"/> Pre-authorized Debit <i>(please attach a Pre-Authorized Debit Agreement and the first month's premium)</i> <input type="checkbox"/> Cheque									
<b>Requested Effective Date of this Plan:</b>									
1st day of _____, 20_____									

G. Declaration	
<p>The applicant hereby declares that the statements and answers contained herein are full, complete and true as of the date hereof and expressly agrees that: (1) such statements and answers shall constitute the application for the contract and form part of the contract, and (2) the coverage shall become effective in accordance with and subject to the policy to be issued to the applicant but in no case shall it become effective until this application has been approved by Group Medical Services (GMS). GMS will not be liable to the applicant or any of the applicant's employees until the application is approved. The applicant understands that Life, AD&amp;D, Dependant Life, Long Term Disability, Short Term Disability and Critical Illness are provided by Assumption Life and that GMS acts as the policyholder for pooled products and has the authority to approve/decline. As such, any policy providing such coverage, if approved by Assumption Life, will be a contract with Assumption Life and the information you have supplied in this application will be provided to and relied on by Assumption Life and included as part of that contract. The undersigned declares that he/she has authority to sign on behalf of the applicant and understands that, whether before or after the date of application, any misrepresentation, incorrect or concealed information or failure to fully complete all sections of the application may void coverage.</p>	
<p><b>Do not terminate any existing coverage until notice has been given in writing that the coverage being applied for is approved by GMS.</b></p>	
<p>Dated at _____ this _____ day of _____, _____.</p>	
<p>by _____ Applicant Signature</p>	<p>_____ Please print name and title</p>

<b>Office Use Only:</b> Date Received:	DD / MM / YYYY	Group #:		RSL:		Agent #:	1129688
--	----------------	----------	--	------	--	----------	---------



Please be sure to complete all sections of this form, then return it to your Plan Administrator.

A. General Information (to be completed by Plan Administrator)			
<input type="checkbox"/> New Employee/Member <input type="checkbox"/> Re-hire <input type="checkbox"/> Termination <input type="checkbox"/> Changing Information If changing information, reason for change:			
Employer/Group Legal Name		Operating Name (complete if different from legal name)	
Employee/Member Occupation	Class	Regular Hrs/Wk	Annual Earnings
Permanent Full-Time Hire Date (DD/MM/YYYY)		Coverage/Change/Termination Effective Date (DD/MM/YYYY)	
<b>Re-hire</b> (If re-hire is within six months, coverage will be effective as of the re-hire date; otherwise the waiting period must be served.)			
Date Previous Employment Ended (DD/MM/YYYY)		Re-hire Date (DD/MM/YYYY)	
Signature of Plan Administrator <b>X</b>			Date (DD/MM/YYYY)

B. Employee/Member Information - Initial Application or Changing Information (to be completed by the employee/member)			
First Name	Last Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (DD/MM/YYYY)
Address	City	Province	Postal Code
Phone (     )	Email	Provincial Health Care Coverage in Place? <input type="checkbox"/> Yes <input type="checkbox"/> No	

C. Family Information - Initial Application or Changing Information (to be completed by the employee/member)						
	First Name	Last (if different from yours)	Sex	Date of Birth (DD/MM/YYYY)	Provincial Health Care Coverage in Place?	Dependant age 21 or over? <sup>2</sup>
Spouse <sup>1</sup>			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A
Dependant			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependant			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependant			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

<sup>1</sup> 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 our dependants claimed for insurance purposes.

<sup>2</sup> For each dependant age 21 and over:

- in the case of a student dependant under age 25, please complete the over-age dependant questionnaire available at [www.gms.ca](http://www.gms.ca).
- in the case of a dependant due to a developmental or physical disability, please attach or enclose a doctor's note or copy of an equivalent document as evidence.

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)				
Do any listed Applicants have additional coverage with another insurer? <input type="checkbox"/> Yes <input type="checkbox"/> No    If "Yes", please complete the section below.				
Insurance Company Name	Name of Insured Person	Policy/Certificate #	Persons Covered under Plan	Coverage (check all that apply) <input type="checkbox"/> Personal Plan <input type="checkbox"/> Group Plan
			<input type="checkbox"/> Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Dependant	<input type="checkbox"/> Health <input type="checkbox"/> Drug <input type="checkbox"/> Vision <input type="checkbox"/> Dental <input type="checkbox"/> Travel
			<input type="checkbox"/> Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Dependant	<input type="checkbox"/> Health <input type="checkbox"/> Drug <input type="checkbox"/> Vision <input type="checkbox"/> Dental <input type="checkbox"/> Travel

Office Use Only: GMS ID#	Group #	Coverage Effective Date
--------------------------	---------	-------------------------

**E. Waiving Benefits** (complete this section to waive benefits if you and your spouse/dependants have coverage under your spouse's plan)

- Waive Health for myself and spouse/dependant(s)       Waive Dental for myself and spouse/dependant(s)  
 Waive Health for my spouse/dependant(s) ONLY       Waive Dental for my spouse/dependant(s) ONLY

Spouse's Insurance Carrier	Plan/Policy Number
Employee Signature <b>X</b>	Date (DD/MM/YYYY)

**NOTE:** If you or your spouse/dependant(s) lose coverage under your spouse's plan, you can enrol in this plan. To enrol, you must complete and submit an enrolment form within 31 days of losing coverage. If you apply after 31 days, you may be required to complete a medical questionnaire to qualify for coverage.

**F. Life Insurance Beneficiary Designation** (complete this section if this group benefit plan includes coverage for Life Insurance)

Beneficiary First Name	Beneficiary Last Name	Date of Birth (DD/MM/YYYY)	% Share	Relationship
				<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
				<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
				<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
				<input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable
If the designated beneficiary is a minor, I appoint the following person as trustee.			Relationship	

**NOTE:** Unless otherwise stipulated or not permitted by law, any beneficiary designation is revocable. If a beneficiary is named irrevocably, please note that his/her consent is required for any request that may affect his/her rights, including a change of beneficiary.

**Complete the following if you are making a change to an Irrevocable Beneficiary.** (The effective date of the beneficiary change will be the date this form is signed.)

Signature of Previous Irrevocable Beneficiary <b>X</b>	Print Name of Previous Irrevocable Beneficiary	Date (DD/MM/YYYY)
---	--	-------------------

**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 their designated travel assistance representative(s), affiliate, reinsurer, agent, or independent claims administrator acting on behalf of GMS (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.

GMS may, for the purposes of administering any benefits, products or services to be provided pursuant to this policy, for the purposes set out in the GMS privacy statement and for the purposes of determining eligibility for benefits: (a) collect, store and use any personal information about you, which you have provided to GMS, or any personal information which GMS has obtained pursuant to clause (b); and/or (b) obtain personal information about you from, or disclose such personal information to: my government health plan; the operator of any hospital, clinic, or other health facility; a physician 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 in (a) 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) and confirm that each of the above declarations and authorizations are also provided on behalf of such person(s).

I understand my group benefit plan may include but not be limited to coverage for Life, AD&D, Dependant Life, Short Term Disability, Long Term Disability, Critical Illness, Second Medical Opinion, EFAP or other such services as may be determined from time to time. Benefits and services may be provided by an affiliate, reinsurer, agent, or independent claims administrator acting on behalf of GMS. The affiliate, reinsurer, agent or independent claims administrator that GMS has partnered with has the authority and responsibility for assessing and or approving my application for such benefits and services and any claims made thereunder. As such, any information concerning insurance coverage, medical care, advice, treatment or supplies or any other information that may have bearing on the request for benefits or services submitted in conjunction with this policy may be requested and relied upon for determining eligibility of benefits.

In the event of death, I authorize any beneficiary, heir or executor to provide GMS, any insurer and/or reinsurer with all information or authorizations deemed necessary for claims adjudication purposes and for obtaining supporting documents. I authorize any coroner, police force or toxicologist that holds my personal information, including any accident and police investigation reports regarding a claims analysis following death, disability or dismemberment, to exchange such information with GMS, any insurer and/or reinsurer. I also authorize the communication of my personal information (other than of a medical nature) to any private investigator and authorize this private investigator to communicate any information collected regarding me to GMS, any insurer and/or reinsurer.

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.

Employee/Member Signature <b>X</b>	Date (DD/MM/YYYY)
---------------------------------------	-------------------

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