GMS GROUP ADVANTAGE®
Group Insurance Application

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 ❑ New Application ❑ 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

❑ Corporation ❑ Partnership ❑ Proprietorship ❑ Association ❑ 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
❑	❑		
❑	❑		

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)

❑ Permanent Full-time	❑ Permanent Part-time	❑ Contract or Seasonal

C. Class Selection

How many classes of employees will be eligible for benefits?

❑ Single Class

❑ Multiple Classes *(examples of classes could be Owners, Managers, All other employees. A minimum 2 lives per class required for multiple classes)*

Class A classifications: _____ Class B classifications: _____

D. Selection of Coverage

Health & Dental Coverage

	Class A	Class B
Health	# of singles _____ ❑ Silver # of couples _____ ❑ Gold # of families _____ ❑ Platinum	# of singles _____ ❑ Silver # of couples _____ ❑ Gold # of families _____ ❑ Platinum
Dental	# of singles _____ ❑ Silver # of couples _____ ❑ Gold # of families _____ ❑ Platinum Coverage Maximum: ❑ $500 ❑ $1,000 ❑ $1,500 ❑ $2,000	# of singles _____ ❑ Silver # of couples _____ ❑ Gold # of families _____ ❑ Platinum Coverage Maximum: ❑ $500 ❑ $1,000 ❑ $1,500 ❑ $2,000
Health Care Spending Account	# of employees _____ ❑ No carry forward ❑ Carry forward Allotment Amount _____ *(min of $250 to max of $15,000 increased by $50 increments)*	# of employees _____ ❑ No carry forward ❑ 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
Life + AD&D	❑ $10,000 ❑ $25,000 ❑ $50,000 ❑ 1xAnnual Salary	❑ $10,000 ❑ $25,000 ❑ $50,000 ❑ 1xAnnual Salary
Dependent Life	❑ $5,000 (spouse) / $2,500 (dependents) of coverage ❑ $10,000 (spouse) / $5,000 (dependents) of coverage	❑ $5,000 (spouse) / $2,500 (dependents) of coverage ❑ $10,000 (spouse) / $5,000 (dependents) of coverage
Traditional Critical Illness or **High Severity Critical Illness**	❑ ❑ $10,000 ❑ $25,000 (Available to groups of 6 -10) ❑	❑ ❑ $10,000 ❑ $25,000 (Available to groups of 6 -10) ❑
***Dependent Critical Illness** (Same as above)	❑ $5,000 (spouse) / $2,500 (dependents) of coverage ❑ $10,000 (spouse) / $5,000 (dependents) of coverage	❑ $5,000 (spouse) / $2,500 (dependents) of coverage ❑ $10,000 (spouse) / $5,000 (dependents) of coverage
Short Term Disability	❑ Yes ❑ No	❑ Yes ❑ No
Long Term Disability	❑ Yes ❑ No	❑ Yes ❑ No
Second Medical Opinion	❑ Yes ❑ No	❑ Yes ❑ No

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

E. 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

F. 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 *(Traditional or High Severity Critical Illness required)*	%	%	%	%
Short Term Disability	%	%	%	%
Long Term Disability	%	%	%	%
Second Medical Opinion	%	%	%	%

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

G. Payment

Choose one of the following payment options.

❑ Pre-authorized Debit *(please attach a Pre-Authorized Debit Agreement and the first month's premium)* ❑ Cheque

Requested Effective Date of this Plan:

(To avoid delayed Effective Date &/or claim payments, the complete application package must be received at GMS Head Office10 business days prior to the Requested Effective Date of this Plan.)

1st day of _____ , 20_____

H. Declaration

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&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.

Do not terminate any existing coverage until notice has been given in writing that the coverage being applied for is approved by GMS.

Dated at_____ this_____ day of_____ , _____ .

by _____ _____

Applicant Signature *Please print name and title*

Office Use Only: Date Received: DD / MM / YYYY Group #: RSL: Agent #: 1129688

PRE-AUTHORIZED DEBIT (PAD) Agreement

Please complete this PAD Agreement and return it, along with payment for the first month's premium, to: *Administration* at *Group Medical Services, 2055 Albert Street PO Box 1949 Regina, SK S4P 0E3*. The original signed form is required for pre-authorized debits to be authorized.

A. General Information

GMS ID No. *(if applicable)*	Group Plan No. *(if applicable)*	Date *(MM/DD/YYYY)*

Please indicate what type of use this PAD Agreement is for:

☐ Business *(I am an employer paying my employee's premium.)*

Employer Name	Employee Name

☐ Personal *(I am an individual paying my own premium.)*

First Name	Last Name	Date of Birth *(MM/DD/YYYY)*

B. Account Information

Financial Institution Name	Address	
City	**Province**	**Postal Code**

Please include a void cheque with this agreement and fill out the numbers below.

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

Type of Account *(only Canadian accounts are acceptable)*	I request regular monthly payments for the full amount of services delivered to be debited from my account on the	
☐ Savings ☐ Chequing	☐ 1st or ☐ 15th *(only choose one date)*.	

C. Declaration

I/We ("I") authorize Group Medical Services (GMS), and the financial institution designated to begin deductions as per my/our ("my") instructions for monthly regular recurring payments and/or one-time payments following notification by written notice, for all charges arising under my GMS account(s).

I waive my right to receive pre-notification of the amount of the PAD and agree that I do not require advance notice of the amount of PADs before the debit is processed.

This PAD Agreement may be cancelled at any time provided notice is received, in writing, at the address provided above at least 10 business days before the next debit 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 debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

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.*

Please remember the following when using Pre-Authorized Debit:

- Payment for the first month's premium amount must be included with this application.
- You may be subject to an administration charge for each monthly withdrawal.
- Non-Sufficient Funds (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 charge and GMS' standard NSF policy can be found on gms.ca.
- Withdrawal payments will continue until such time as written notice to the contrary is given, in accordance to the right of termination of this PAD Agreement.
- 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 be processed.

ONLINE ADMINISTRATION AGREEMENT
Account Registration Form

Each user that has permission to access a group's information through GMS' online administration tool must complete this form. All account registration forms must be signed by an Authorized Group Benefit Plan Administrator. Please use any of the methods below to send us your completed form.

mail Group Medical Services 2055 Albert Street PO Box 1949 Regina, SK S4N 5P4 **fax** 306.525.6360 **email** info@gms.ca

Accounts take approximately two business days to be set up. Once an account has been set up a confirmation email will be sent to the user's email address. Users must click on the activation link in the confirmation email within seven days. Please be sure to keep login information private and confidential.

A. Company Information

Company Name *(herein referred to as the "Client")*			
Address	City	Province	Postal Code
Phone	Fax	Email	

B. User Information

Name of User *(please print)*	Email		Date of Birth *(DD/MM/YYYY)*
Address	City	Province	Postal Code

C. Group Medical Services Online Administration User Agreement

I hereby agree to maintain the integrity of the Group Medical Services ("GMS") Online Administration System ("OAS") by keeping my username and password confidential. I agree that upon ceasing to hold my current position I will notify GMS at 1.800.667.3699 to ensure my OAS user access is cancelled prior to my change of position. I acknowledge that access to or use of the OAS for non-work related purposes and hacking or reverse engineering of the OAS are illegal and subject to prosecution by both the Client and GMS. I acknowledge that GMS has an absolute right to monitor and track use of the OAS including a right to identify the operating system a user may use to access the OAS. Under no circumstances does the Client or its users have the permission to release their access information or viewing rights to any competitive insurer or private customer.

User Signature **X**	Date *(DD/MM/YYYY)*
Authorized Group Administrator Signature **X**	Date *(DD/MM/YYYY)*

Note: *It is the ultimate responsibility of the Client to ensure CURRENT employees are the only user(s) that have access to the Group Medical Services Online Administration System, and that proper use of the site is being maintained. Please advise in writing any termination of Group Administrators/Users so access can be changed.*