GMS

GMS GROUP ADVANTAGE®
Employee Enrolment/Change Form

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)*

❑ New Employee ❑ Re-hire ❑ Termination ❑ Changing Information

If changing information, reason for change:

Company			
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)*		

Re-hire *(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 **X**	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 ❑ M ❑ F	Date of Birth *(DD/MM/YYYY)*
Address	City	Province	Postal Code
Phone ( )	Email	Provincial Health Care Coverage in Place? ❑ Yes ❑ 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?[2]
Spouse[1]			❑ M ❑ F		❑ Yes ❑ No	N/A
Dependant			❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No
Dependant			❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No
Dependant			❑ M ❑ F		❑ 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 our dependants claimed for insurance purposes. I further verify that I am not obligated to provide coverage for my legal spouse.

[2] For each dependant age 21 and over:

- in the case of a student dependant under age 25, please indicate the educational institution where the child is receiving full-time training:

- 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? ❑ Yes ❑ 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)* ❑ Personal Plan ❑ Group Plan
			❑ Applicant ❑ Spouse ❑ Dependant	❑ Health ❑ Drug ❑ Vision ❑ Dental ❑ Travel
			❑ Applicant ❑ Spouse ❑ Dependant	❑ Health ❑ Drug ❑ Vision ❑ Dental ❑ Travel

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

E. 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 enrol 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

Employee Signature	Date *(DD/MM/YYYY)*
X	

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

Beneficiary First Name	Beneficiary Last Name	Relationship	% Share

If the designated beneficiary is a minor, I appoint the following person as Trustee:

Your beneficiary designation will not be revoked or changed automatically by any future marriage or divorce.
If you wish to change your beneficiary, you will have to make a new designation below.

Life Beneficiary Change *(the effective date of the Beneficiary change will be the date this form is signed)*

❑ Change of Name Only ❑ Change of Beneficiary	Relationship to Plan Member	Name of Beneficiary *(last, first, middle initial)*

Signature of Previous Irrevocable Beneficiary

X

I appoint the following person as Trustee to receive any amount due to any beneficiary under the age of 18:

Coverage for Life, AD&D, Dependant Life, Weekly Indemnity, Employee Assistance Program, Critical Illness and Long Term Disability is provided by The Co-operators Life Insurance Company

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) (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 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: any Government 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).

If my GMS Group Advantage® plan includes coverage for Life, AD&D, Dependant Life, Weekly Indemnity, Long Term Disability, Employee Assistance Program and Critical Illness, I understand that these benefits are provided by The Co-operators Life Insurance Company ("The Co-operators") and that GMS acts only as the administrative agent for The Co-operators in placing and administering such coverage. The Co-operators and not GMS has the authority and responsibility for assessing and approving your application for such coverage and any claims made thereunder. As such, any policy providing such coverage, if approved by The Co-operators, will be a contract with The Co-operators and the information you have supplied in this application will be provided to and relied on by The Co-operators and included as part of that contract.

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	Date *(DD/MM/YYYY)*
X	

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