

C. Physician Information

Applicant #	Physician Name	Phone Number (include area code)
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D. Medical Information

D1. Health Conditions and Procedures

Has any Applicant consulted a physician or specialist about, suffered from, been diagnosed with, received treatment or taken prescription drugs for any of the following in the past two years? (If "Yes," please circle the condition(s), and indicate which Applicant #)

Conditions and Procedures		Applicant #
Heart Attack / Congestive Heart Failure / Angina / Irregular Heartbeat / Other Heart Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Stroke / TIA / Blood Clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Aneurysm / Peripheral Vascular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Home Oxygen Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Liver Disease / Kidney Disease and/or Failure / Bladder Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Gastrointestinal Disorder / Crohn's / Colitis / IBS	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cancer / Tumor / Any Terminal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
AIDS / HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Arthritis / Rheumatism / Musculoskeletal Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any other Disease / Disorder / Condition or Physical Impairment? (Please specify in D2 below)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Two or more episodes of Fainting or Falling? (Please specify in D2 below)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

D2. Explanation of Health Conditions

If any Applicant answered "Yes" to any condition in question D1, please explain below.

Applicant #	Condition	Date Diagnosed (DD/MM/YYYY)	Results & Extent of Recovery

D3. Health Practitioners

Has any Applicant, during the past two years, consulted, received advice or treatment or been advised to seek treatment from a chiropractor, physiotherapist, massage therapist, psychologist, podiatrist or acupuncturist? Yes No (If any Applicant answered "Yes" to the above, please give details below)

Applicant #	Practitioner	Condition	Date Diagnosed (DD/MM/YYYY)	Results & Extent of Recovery

D4. Future Procedures

a) Is any Applicant currently on a waiting list, scheduled for or otherwise awaiting hospitalization or surgery? Yes No

b) Have any tests or exams been advised by a doctor, but not yet completed? Yes No

(If any Applicant answered "Yes" to either of the above questions, please give details below)

Applicant #	Condition	Type of Treatment	Expected Date of Treatment (DD/MM/YYYY)

E. Prescription Medication

Has any Applicant taken any prescription medication in the past 6 months or have a prescription for which refills are currently authorized?

Yes No (If any Applicant answered "Yes" to either of the above questions, please give details below)

Applicant #	Prescription Name, Strength & Dosage	Medical Condition	Length of Time Used	Refills Authorized

F. Coverage Selection & Rate Calculation

Health Plan & Options (Choose a Health Plan. All Applicants will receive the same coverage.)

Monthly Premium

OmniPlan® OmniPlan® - Enhanced ExtendaPlan® BasicPlan

Options: (if purchasing a health plan)

Prescription Drug OR Prescription Drug - Enhanced

Dental Care

Hospital Cash

Annual Travel - 15 Days OR Annual Travel - 30 Days OR Annual Travel - 48 Days

Total Monthly Premium

NOTE: Families with more than six people - please add 30% to the Family rate.

G. Coverage Effective Date

Application Date (DD/MM/YYYY)

I would like my coverage to be effective on:

the 1st OR the 15th

NOTE: the coverage effective date will be the 1st or 15th immediately following the Application Date. For example, an Application Date of August 6 would result in a coverage effective date of August 15 or September 1. Group Medical Services must approve your application and receive the appropriate premium before coverage becomes effective. Waiting periods apply to some benefits. Coverage will be governed by the terms and conditions described in the policy which can be viewed on www.gms.ca. A copy of the policy will be sent to you upon acceptance of your application by GMS. If an adjustment has been made to your policy and you are not fully satisfied, you will have seven days from confirmation of coverage to obtain a full refund.

H. Payment Options

Annual (Total Monthly Premium as calculated in Section F x 12)

Payment Amount

\$

Cash

Cheque

Visa

MasterCard

Credit Card Number

Security Code

Expiry Date (MM/YY)

Signature of Cardholder

X

Monthly Pre-Authorized Debit (Please attach a Pre-Authorized Debit Agreement and the first month's premium)

I. 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 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).

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.

Signature of all Applicants 18 years of age and older

Date (DD/MM/YYYY)

X

Periodically, GMS may send information to you in order to develop and recommend suitable products and services. Check here if you do not wish to receive this information.

J. 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

Agent #2

Split

A1% / A2%

For Office Use:

Effective Date:

DD/MM/YYYY

GMS ID: