

The complete application package and first month's premium must be received at GMS Head Office 5 to 7 business days prior to the Requested Effective Date of this Plan.

A. Applicant Information			
Employer/Group Name <input type="checkbox"/> New Application <input type="checkbox"/> Revision to Present Plan			
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	
Group Administrator(s)			
Primary	First Name	Last Name	Title
	Phone ()	Fax ()	Email
Secondary	First Name	Last Name	Title
	Phone ()	Fax ()	Email

B. Waiting Period & Number of Employees			
Waiting period for new employees hired after effective date of insurance: <input type="checkbox"/> 3 months <input type="checkbox"/> Other (please specify) _____			
<input type="checkbox"/> Permanent Full-time # _____	<input type="checkbox"/> Permanent Part-time # _____	<input type="checkbox"/> Contract or Seasonal # _____	<input type="checkbox"/> Other # _____

C. Selection of Coverage			
Premium Contributions:			
	Employer %	Employee %	
Extended Health Care			Dental Care

Premium Calculation: (For GMS Group Advantage Health and Dental rates, please refer to the supplied Monthly Rates Pre Employee Schedule.)

Health Coverage			Dental Coverage		
<input type="checkbox"/> Silver	# of Single _____ X Rate _____	\$ _____	<input type="checkbox"/> Silver	# of Single _____ X Rate _____	\$ _____
<input type="checkbox"/> Gold	# of Family _____ X Rate _____	\$ _____	<input type="checkbox"/> Gold	# of Family _____ X Rate _____	\$ _____
<input type="checkbox"/> Platinum			<input type="checkbox"/> Platinum		
<input type="checkbox"/> Diamond					
Total Health			Total Dental		
\$ _____			\$ _____		

Office Use Only: Date Received: DD / MM / YYYY	BDC: _____	Agent #1: _____	Agent #2: _____	Split: A1% / A2%
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D. Optional Life & Disability Coverage

For Life & Disability rates, please see your GMS Insurance Broker or Business Development Consultant for a quotation. If you choose to add Life & Disability coverage, please attach a copy of the accepted quote to this application.

Premium Contributions:

	Employer %	Employee %		Employer %	Employee %		Employer %	Employee %
Life/AD&D			Weekly Indemnity			Employee Assistance Program		
Dependant Life			Long Term Disability			Critical Illness		

Life & Disability Coverage

Life (monthly Cost per \$1,000)	\$	Long-Term Disability (monthly Cost per \$100)	\$
AD&D (monthly Cost per \$1,000)	\$	Employee Assistance Program (monthly cost per employee)	\$
Dependant Life (monthly Cost per Family)	\$	Critical Illness (monthly cost per \$1,000)	\$
Weekly Indemnity (monthly Cost per \$10)	\$		

E. Payment

Total Monthly Premium

Health \$ _____ + Dental \$ _____ + Life & Disability \$ _____ + PST (Ontario Only) \$ _____ = \$ _____
Total Monthly Premium

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:

1st day of _____, 20_____

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F. Additional Information

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

Yes No

Is this plan intended to replace any existing coverage?

Yes No If Yes, please complete the following section.

Benefit <i>check all that apply</i>	Name of Current Carrier	Effective Date of Present Coverage
<input type="checkbox"/> Extended Health Care <input type="checkbox"/> Dental Care <input type="checkbox"/> Life <input type="checkbox"/> Weekly Indemnity <input type="checkbox"/> Long-Term Disability <input type="checkbox"/> Critical Illness <input type="checkbox"/> AD&D <input type="checkbox"/> Dependant Life <input type="checkbox"/> Employee Assistance Program		

G. 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, Weekly Indemnity, Long Term Disability, Employee Assistance Program and Critical Illness 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. 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