



Please complete all sections and submit to: Group Medical Services #200 - 3303 Hillsdale Street, Regina, SK S4S 7J8

A. Personal Information

First Name Last Name Date of Birth DD/MM/YYYY
Address City Province Postal Code
Home Tel () Email GMS Policy #

B. Cancellation & Interruption Claims

Describe the circumstances which resulted in the cancellation/interruption of your trip:

Large empty text box for describing trip cancellation/interruption circumstances.

If you cancelled your trip due to the illness or death of a family member, please state your relationship

Date of the Cause of the Cancellation DD/MM/YYYY OR, Date of the Interruption DD/MM/YYYY

Date Travel Supplier Notified DD/MM/YYYY

Total Amount Paid for Travel Arrangements: \$ Amount Refunded From any Source: \$

Amount Being Claimed: \$ Are you claiming loss: prior to departure after departure

Claimant's Signature X Date DD/MM/YYYY

C. Other Insurance Coverage

Please provide details of any additional insurance coverage relating to this claim (attach additional information if necessary).

Do you or your spouse have benefits through any other plan? Yes No If yes, complete the following:

Type of Plan Policy/ID/Credit Card #

Name and Address of Bank/ Credit Card or insurance Company

Have you filed a claim? Yes No

D. Authorization to Physicians and other Medical Providers and Insurance Companies

I/We declare the statements made herein are true and complete. I understand that any material misrepresentation or incorrect information will void my coverage. I authorize Group Medical Services to (a) store and use any information which I have provided or information which it obtained pursuant to clause (b) for the purposes of administering this plan; and (b) for the purposes of determining my eligibility for benefits under this plan, to obtain information from, or provide information to: your provincial health plan; the operator of any hospital, clinic or other health care facility; a physician or other health care provider; any insurance company; or any other service provider as may be required.

Signature of Claimant X

Name of Claimant (Please Print) Date DD/MM/YYYY

E. Treating Physician's Statement

Name of Patient _____

Nature of Injury or Sickness:

When did the patient first consult you with this condition? DD / MM / YYYY

On what date was the patient diagnosed with this condition? DD / MM / YYYY

Date you last treated patient for this condition prior to travelling: DD / MM / YYYY

Was the patient awaiting further investigation or treatment regarding this condition? Yes No

Give dates and list treatment, including any medication prescribed and/or changed for this condition or related conditions within the last 6 months:

Are you the patient's regular physician? Yes No

Are you aware of any other physician who may have treated this patient, for this or a similar condition? Yes No

If yes, please specify who _____

Did the patient seek medical approval from you for this trip? Yes No

If yes, give a summary of advice given and the date of this consultation:

Is condition due to pregnancy? Yes No If yes, what is the expected date of delivery? DD / MM / YYYY

Is condition due to an accident? Yes No If yes, what was the date of the accident? DD / MM / YYYY

Was patient hospitalized? Yes No If yes, what was the date of admission DD / MM / YYYY and discharge? DD / MM / YYYY

Name of Hospital _____

Date Traveller Made You Aware of His/Her Travel Plans DD / MM / YYYY

In your medical opinion, give the date patient was assessed as unfit to travel DD / MM / YYYY

If above date differs from the date the condition was diagnosed, please explain briefly:

F. Declaration

I certify that the information I have provided is correct and true to the best of my knowledge.

Physician's Signature **X** _____ Date DD / MM / YYYY

Complete Name and Address _____

Phone Number (_____) _____ Fax Number (_____) _____

Physician's Stamp