G | m | s
Group Medical Services

TravelStar®
Application

TC

A. Applicant Information

Applicant	First Name	Last Name	Sex	Date of Birth (DD/MM/YYYY)	Age
1			❑ M ❑ F		
2			❑ M ❑ F		

For more than 2 applicants, please complete an additional application form or apply online at www.gms.ca.

Address	City	Province	Postal Code

Phone	Email
( )	

Local Contact and Phone Number in Case of Emergency

B. Physician Information *(Complete this section when purchasing any Emergency Medical Insurance)*

Applicant	Physician Name	Phone Number *(include area code)*
1		( )
2		( )

C. Eligibility

Eligibility Requirement *(Complete this section when purchasing any Emergency Medical Insurance or Trip Cancellation & Interruption Insurance for a trip of greater than $12,000 in value)*

1. Are you awaiting further tests or treatment for heart disease or have you ever been diagnosed with congestive heart failure (CHF)?
2. Do you have both heart disease and insulin dependent diabetes and take prescription medication for both?
3. Do you use home oxygen for a heart and/or lung disease?
4. Do you take oral steroids for a lung condition?
5. Do any of the following apply to you: You are under active treatment for cancer, have an aortic or intracranial aneurysm that remains surgically untreated, or have experienced undiagnosed episodes of syncope/fainting or falling?
6. Do you have an ICD (Implantable Cardioverter Defibrillator)?
7. In the past 12 months:
   a) have you suffered from, been diagnosed with, received new treatment for, or had a recurrence of, or complications relating to any of the following: stroke/TIA, blood clots, atrial flutter, atrial/ventricular fibrillation, peripheral vascular disease, AIDS, any terminal illness, renal/liver failure, or gastrointestinal bleeding?
   b) have you undergone the following procedures: renal dialysis, valve replacement, valve surgery or organ transplant?

If you answered YES to any of the above questions, you are NOT eligible to purchase this plan.

I hereby warrant that I AM eligible to purchase this plan.	**Applicant 1** ❑ **Yes**	**Applicant 2** ❑ **Yes**

Eligibility Requirement *(Complete this section when purchasing Trip Cancellation and Interruption Insurance, Non-Medical Inclusive or All Inclusive plans.)*

You must purchase this insurance prior to your departure date and within seven (7) days of purchasing a flight or trip that is non-refundable after the date of booking or prior to incurring any cancellation penalties.

I hereby warrant that I AM eligible to purchase this plan.	**Applicant 1** ❑ **Yes**	**Applicant 2** ❑ **Yes**

D. Medical Questionnaire *(Complete this section if you are aged 60 or older and are purchasing Single Trip Daily Emergency Medical Insurance)*

D1. Have you ever suffered from, been diagnosed with, received treatment for, or taken prescription medication for any of the following or undergone any of the following medical procedures: *(Please circle each applicable condition/procedure)*

Conditions and Procedures	Applicant 1	Applicant 2
a) Heart/Cardiovascular Disease or Condition, Heart Attack, Angina, Irregular Heartbeat, Heart Surgery, Coronary Angioplasty, Stenting, Bypass, Valve Replacement or Valve Surgery?	❑ Yes ❑ No	❑ Yes ❑ No
b) Stroke/TIA, Blood Clots, Aneurysm, Peripheral Vascular Disease, Carotid Stenosis?	❑ Yes ❑ No	❑ Yes ❑ No
c) Chronic Lung Disease (e.g. Chronic Obstructive Pulmonary Disease (COPD)/Emphysema/Persistent Asthma)?	❑ Yes ❑ No	❑ Yes ❑ No
d) Bone Marrow or Organ Transplant?	❑ Yes ❑ No	❑ Yes ❑ No
e) HIV?	❑ Yes ❑ No	❑ Yes ❑ No

D2. In the past two years prior to your date of departure from your province of residence, have you suffered from, been diagnosed with, received treatment for or taken prescription medication for: *(Please circle each applicable condition/procedure)*

	Applicant 1	Applicant 2
a) Cancer (Excluding Basal Cell Carcinoma), Diabetes, Pancreatitis?	❑ Yes ❑ No	❑ Yes ❑ No
b) Chronic Kidney Disease, Liver Disease, Gastrointestinal Disorder (e.g. ulcers, G.I. bleed, bowel obstruction)?	❑ Yes ❑ No	❑ Yes ❑ No
c) Epilepsy or Seizures, M.S., Lou Gehrig's Disease, Parkinson's Disease, Dementia, Alzheimer's?	❑ Yes ❑ No	❑ Yes ❑ No
D3. Has it been more than 18 months since your last check-up with a physician?	❑ Yes ❑ No	❑ Yes ❑ No

Rate Category

Star: If you have answered NO to all questions, you qualify for **Star** Rates.

Select: If you have answered YES to one or two of the conditions or procedures in question **D2** or **D3**, you qualify for **Select** Rates

Standard: If you have answered YES to any condition or procedure in question **D1**, OR if you have answered YES to three or more conditions or procedures in questions **D2** & **D3**, you qualify for **Standard** Rates.

OPTIONAL Medical Review *(for Single Trip Daily only)*

	Applicant 1	Applicant 2
Applicants may request a review of their medical information. If you are concerned about your coverage due to your specific medical condition(s), GMS offers to prescreen your application. List all medical conditions and/or symptoms you have been diagnosed with, suffered from and/or have been treated for in the last 24 months, including any further treatment or investigation which is pending. Include the original date diagnosed, treatment and any changes in the conditions or symptoms. GMS will review the application and contact the applicant directly.	❑ Yes ❑ No	❑ Yes ❑ No

Applicant #	Condition or Procedure, Date Diagnosed or Performed *(DD/MM/YYYY)*	List of Prescribed Medications	Date of Initial Prescription *(DD/MM/YYYY)*	Date of Most Recent Change *(DD/MM/YYYY)*

E. Coverage Selection & Rate Calculation

Trip Information *(required for Single Trip or TCI)*

Departure Date *(DD/MM/YYYY)*	Return Date *(DD/MM/YYYY)*	Total Trip Length *(the total number of days for your trip including Departure and Return Dates)*

Emergency Medical Insurance			**Applicant 1**	**Applicant 2**
❑ Single Trip Daily	Rate Category: ❍ Star ❍ Select ❍ Standard Deductible: ❍ $250 ❍ $0 *(add 10% to daily rate)*	❑ Top-up to an Existing Coverage # of Days of Existing Coverage:		
	GMS Coverage Effective Date *(DD/MM/YYYY)*	No. of days of GMS Coverage: x Daily Rate *(based on total trip length)* $	$	$
❑ Multi-Trip Annual	❍ 30 Day ❍ 15 Day	Effective Date of Annual Plan *(DD/MM/YYYY)*	$	$
Non-Medical Insurance				
❑ Trip Cancellation & Interruption *(TCI)*	SUM Insured $		$	$
❑ Baggage Loss, Damage & Delay *(requires the purchase of TCI)*	SUM Insured $	No. of Days	$	$
❑ Non-Medical Inclusive Single Trip *(TCI & Baggage)*	SUM Insured $	No. of Days	$	$
❑ Non-Medical Inclusive Multi-Trip *(TCI & Baggage)*	❍ 30 Day ❍ 15 Day	SUM Insured $	$	$
All-Inclusive				
❑ All-Inclusive Single Trip *(Medical, TCI, Baggage)*	SUM Insured $	No. of Days	$	$
❑ All-Inclusive Multi-Trip *(Medical, TCI, Baggage)*	❍ 30 Day ❍ 15 Day	SUM Insured $	$	$
Coverage Options *(available when purchasing TCI and Baggage, Non-Medical Inclusive or All-Inclusive plan; Multi-Trip options require purchase of a Multi-Trip Plan)*				
❑ Trip Delay Upgrade *(requires the purchase of TCI)*	❍ Single Trip **$21**	❍ Multi-Trip **$53**	$	$
❑ Increased Per-Item Baggage Limit *(requires the purchase of a plan with TCI and Baggage coverage)*	❍ Single Trip QTY: **x $21**	❍ Multi-Trip QTY: **x $53**	$	$
	Description of Item:			
❑ Golf Clubs, Skis, Sports Equipment *(requires the purchase of a plan with TCI and Baggage coverage)*	❍ Single Trip QTY: **x $26**	❍ Multi-Trip QTY: **x $63**	$	$
	Description of Item:			
❑ Laptops, Computer Equipment *(requires the purchase of a plan with TCI and Baggage coverage)*	❍ Single Trip QTY: **x $26**	❍ Multi-Trip QTY: **x $63**	$	$
	Description of Item:			
		Premium TOTAL	$	$

F. Payment Options

Payment Amount *(Applicant 1 + Applicant 2 total)*

❑ Cash ❑ Cheque ❑ Visa ❑ MasterCard

Credit Card Number	Security Code	Expiry Date *(MM/YYYY)*	Signature of Cardholder
			X

Coverage will be effective upon Group Medical Services approval of the application and receipt of the appropriate premium. If an adjustment has been made to your policy and you are not fully satisfied, you will have seven (7) days from confirmation to obtain a full refund, provided you have not travelled under this policy.

G. Other Coverage Information

Do any listed Applicants have a GMS travel plan, group policy and/or coverage with another Insurer or Credit Card for this trip?

❑ Yes ❑ No *(If "Yes," please complete the section below)*

Applicant #	Insurer/Credit Card	Policy/Certificate #

H. 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 concerning 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

Applicant 1 Signature	Application Date *(DD/MM/YYYY)*
X	
Applicant 2 Signature	Application Date *(DD/MM/YYYY)*
X	

Products available for purchase in the provinces of British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Prince Edward Island, Nova Scotia and Newfoundland.

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: [ ]