gms

NSGREA BENEFITS PROGRAM
Enrolment Form

Please remember to include a Pre-Authorized Debit Agreement with this application.
Coverage will be effective the 1st of the month following the date your enrolment form is received and accepted by GMS.

A. Personal Information

You must be a member of NSGREA to enrol in this benefit plan. Are you a member? ❑ Yes ❑ No	Retirement/Loss of Spousal Coverage Date *(DD/MM/YYYY)*

Note: *To enroll in Health coverage, you must complete and submit your enrolment form within 90 days of your retirement date or loss of spousal coverage. If you apply after 90 days, you may be required to complete a medical questionnaire to qualify for coverage.*

For Dental coverage, if your application is received more than 90 days after your retirement date or loss of spousal coverage, you will be considered a Late Applicant. As a Late Applicant, each individual will be limited to a maximum of $300 in dental claims for the first 12 months of coverage.

First Name	Last Name	Date of Birth *(DD/MM/YYYY)*	Sex ❑ M ❑ F

Address	City	Province	Postal Code

Phone ( )	Email	Provincial Health Care Coverage in Place? ❑ Yes ❑ No

B. Coverage Selection

Choose Your Plan	**Select Your Coverage Type** *(Choose a option for health and/or dental. If you enroll in both, coverage type must match)*		
❑ Health Plan	❑ Single	❑ Couple	❑ Family
❑ Dental Plan Option 1	❑ Single	❑ Couple	❑ Family
❑ Dental Plan Option 2	❑ Single	❑ Couple	❑ Family

Optional Travel Coverage

You can only apply for this travel option with your initial application for one of the health or dental options above.

Travel	❑ Yes ❑ No	The rate is based on the oldest individual within the family unit.

C. Family Information

	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 dependents 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 Coverage Information

Are you, your spouse or dependant(s) covered by any other health, dental or travel plan?

❑ Yes *(please complete the following)* ❑ No *(please skip to section E)*

Name of Insured	Start Date of Coverage	End Date of Coverage *(if applicable)*

Insurer	Policy No.	Certificate No.	Plan Type
			❑ Group *(i.e. employer-sponsored)* ❑ Individual

Coverage *(check all that apply)*	Who Is Covered? *(check all that apply)*
❑ Health ❑ Dental ❑ Travel	❑ Me ❑ Spouse ❑ Dependants

E. Declaration

I declare that the information given on this form is true and complete and shall form part of my application for coverage. I hereby authorize any health or dental care provider, other person, hospital or institution to release to GMS 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.

For the purposes of administering any GMS benefits, products or services (collectively "benefits") and/or determining eligibility for benefits, I authorize GMS: (a) to store and use any information which I have provided or information which it obtained pursuant to clause (b); and/or (b) to obtain information from, or disclose information to: my Government Health Insurance Plan; the operator of any hospital, clinic or other health care facility; a doctor or other health care provider; any insurance company; or any other service provider or third party as may be reasonably required.

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 persons(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.

I understand that I am purchasing an annual plan from Group Medical Services, and upon cancellation of this plan, will ensure that any unpaid annual premium is remitted in full immediately.

Signature of Person Enrolling	Date *(DD/MM/YYYY)*
X	

For Office Use Only: Effective Date of Coverage DD / MM / YYYY