

Group Medical Services TravelExtr★s Application

Group Medical Services is the operating name for GMS Insurance Inc.

TE# _____

Name _____ Phone _____

Address _____ City _____ Prov _____ Postal Code _____

Applicant(s)	Health Services Number	Gender	Birth (dy/mo/yr)
1.			/ /
2.			/ /
3.			/ /
4.			/ /

Are any of the applicants covered under another insurance plan or credit card for travel coverage? Yes No

If yes, indicate coverage and applicant #: Medical Cancellation & Interruption Baggage & Personal Effects

Applicant # _____

Name of other carrier: _____ Date of Expiry: _____

If you are applying for the Annual Travel Plan please complete Sections A,C,D,E. If you are applying for Trip Cancellation, Interruption or Baggage please proceed to Sections B,C,D,E.

A. Annual Travel Plan (not available to those 80 years of age and older)

If you are applying for the Annual Travel Plan be sure to read the eligibility requirements below.

You are not eligible to purchase this plan if you:

- are receiving active treatment for cancer
- have a heart/cardiovascular disease and have insulin dependent diabetes
- have a chronic lung and/or heart disease for which you are using home oxygen
- are booked or awaiting further treatment, tests, and/or investigation related to heart disease
- have an aortic aneurysm 4.0 cm or greater which remains surgically untreated
- have COPD (chronic obstructive pulmonary disease) and take oral steroids
- are a hemophiliac
- are suffering from complications from congenital heart surgery
- have an ICD (implantable cardioverter defibrillator)

If you have been receiving treatment, been diagnosed with, or suffered from symptoms in the last 12 months for:

- Any Terminal Illness
- Stroke/TIA
- Renal Failure
- AIDS
- Atrial/Ventricular Fibrillation
- Congestive Heart Failure
- Gastrointestinal Bleed or Bowel Obstruction
- Blood Clots

If you have undergone any of the following procedures in the last 12 months:

- Renal Dialysis
- Valve Replacement
- Carotid Endarterectomy (surgery to open the carotid artery)
- Any Organ Transplant (eg. heart, lung, kidney and/or liver, etc.)

I/We hereby warrant that I do not have any of the above medical conditions.

(We can not process your application for the Annual Travel Plan if this is not completed.)

Physician Information

Applicant # (s) _____ Physician Name _____ Phone number _____

Applicant # (s) _____ Physician Name _____ Phone number _____

Please complete other side of the application. →

Group Medical Services #200-3303 Hillsdale Street Regina SK S4S 7J8 1-866-796-9467

Group Medical Services TravelExtrH s Policy Identification Cards

Name: _____

Coverage Type:

- Annual Travel (you will receive permanent cards)
- Trip Cancellation & Interruption
- Baggage & Personal Effects
- Combined Package (Cancellation, Interruption & Baggage)

Group Medical Services TravelExtrH s Policy Identification Cards

Name: _____

Coverage Type:

- Annual Travel (you will receive permanent cards)
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B. Trip Cancellation, Interruption, and Baggage

Destination Information

Street _____ Phone _____

City _____ Country/State _____ Zip Code _____

Travel Information

Date of initial purchase or deposit (D/M/Y): _____

Application Date (D/M/Y): _____

Departure Date (D/M/Y): _____ Return Date (D/M/Y): _____

Length of trip: _____ Days (When calculating the trip length, include the departure date and the return date).

C. Rate Calculation

Applicant #	Annual Travel	Trip Cancellation & Interruption		Baggage & Personal Effects			Combined Package			Premium per Applicant
	Premium	Sum Insured	Premium	Sum Insured	Days	Premium	Sum Insured	Days	Premium	
1.										
2.										
3.										
4.										
5.										
6.										

Total Premium \$ _____

- Coverage will be effective upon Group Medical Services' approval of the application and receipt of the appropriate premium. Coverage will be governed by the terms and conditions described in the policy which will be delivered 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 7 days from confirmation of coverage to obtain a full refund, provided you have not travelled under this policy.

D. Payment Options

Cash Cheque Debit Visa MasterCard

Credit Card Number _____ Expiry Date _____

Signature of Cardholder _____

If you have chosen a Credit Card payment, by signing above you authorize GMS to charge the total premium to the card indicated.

E. Declaration

I/We declare the statements made herein are true and complete and shall form part of the application for coverage. I hereby authorize any physician, health care provider, other person, hospital or institution to release to Group Medical Services 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 to (a) collect, store and use any personal information which I have provided to GMS or personal information which it 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 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 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) 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 Applicant 1 _____

Date (D/M/Y) _____

Signature of Applicant 2 _____

Date (D/M/Y) _____

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.

If you have the annual travel plan and have a medical emergency while travelling, please call our travel assistance firm at:

Toll free 1-800-877-3061 (from Canada or US)
or
Collect (416) 977-2156 (from other locations)

If you have the Trip Cancellation, Interruption, or Baggage plans and you require assistance or have a claim please call our office at:

Toll free 1-866-796-9467 (from Canada or US)
or
Collect (306)522-4674 (from other locations)

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