Group Medical Services
TravelStar® Application

Group Medical Services** is the operating name of **GMS Insurance Inc. T

Name ______________________ Home Address ______________________

City ______________ Province ________ Postal Code ____________ Phone ______________

Local Contact and Phone Number in Case of emergency ______________________

#Applicant(s) (Last/First name)	Health Services Number	Gender	Birth (dd/mm/yy)
1			/ /
2			/ /
3			/ /
4			/ /

A. Destination Information

Address ______________________________ City ______________

Country/State ______________ Zip Code ______________ Phone ______________

B. Eligibility Requirements

Enrollment is open to all people who have had valid health coverage under the provincial/ territorial government health plan in their last province of residence, and who remain in Canada for a minimum of 180 days of each calendar year (subject to verification). For trips greater that 180 days, contact GMS.

You are **NOT** eligible to purchase this policy if any of the following apply to you:

a) In the 12 months immediately prior to the date of departure from your province of residence, have you suffered from, been diagnosed with, or received treatment for any of the following: Stroke/TIA, Congestive Heart Failure, Atrial/Ventricular Fibrillation, AIDS, Any Terminal Illness, Renal Failure?
Or:
In the 12 months immediately prior to the date of departure from your province of residence, have you undergone the following procedures: Renal Dialysis, Valve Replacement, Carotid Endarterectomy (surgery to open the carotid artery), Any Organ Transplant (eg. heart, lung, kidney and/or liver etc.)?

b) Do any of the following apply to you? Are you booked or awaiting further treatment, tests and/or investigation related to heart disease? Are you under active treatment for cancer? Do you presently have an aortic aneurysm, 4.0 cm or greater, which remains surgically untreated (must be measured within 180 days prior to departure)? Do you presently have both heart disease and insulin dependent diabetes and are taking prescriptions drugs for both? Do you presently have a chronic lung and/or heart disease for which you use home oxygen? Do you presently have COPD (chronic obstructive pulmonary disease) and are taking oral steroids? Are you a hemophiliac? Are you suffering from complications resulting from congenital heart surgery? Do you have an ICD (Implantable Cardioverter Defibrillator)?

❑ **I hereby warrant that I do NOT have the above medical conditions and I am eligible to purchase this travel plan.**

C. Rate Qualification Questions:

Persons age 55 and older must complete the following medical questions. Those under 55 can proceed to Section D on page 2.

1. Have you ever suffered from, been diagnosed with, received treatment, or taken prescription drugs for any of the following or undergone any of the following procedures? Heart disease (eg. Angina, irregular heart beat, etc.), myocardial infarction (heart attack), coronary angioplasty and/or stenting, CABG (coronary artery bypass graft) pacemaker implant or heart ablation, heart surgery, congestive heart failure, any other heart condition, stroke/TIA, aneurysm, organ or bone marrow transplant, HIV, peripheral vascular disease (eg. Narrowing or blockage of the arteries), blood clots or chronic lung disease (eg. Emphysema, COPD (chronic obstructive pulmonary disease), persistent asthma etc.)?

Question 1.	YES	NO
Applicant 1.	❑	❑
Applicant 2.	❑	❑
Applicant 3.	❑	❑
Applicant 4.	❑	❑

If you answered NO to all conditions, continue to question 2. If you answered YES to any condition(s) in question 1, you are eligible for the Standard rates. You must still complete question 2 and 3.

2. In the 2 years immediately prior to your date of departure from your province of residence, have you suffered from, been diagnosed with, received treatment, or taken prescription drugs for cancer (excluding basal cell carcinoma), chronic liver problems, chronic bowel or digestive problems including any related disease, chronic kidney problems, epilepsy or seizure disorders, diabetes, pancreatitis, dementia, Alzheimer's, M.S., Parkinson's, Lou Gehrig's disease, or Myasthenia Gravis?

Question 2.	YES	NO
Applicant 1.	❑	❑
Applicant 2.	❑	❑
Applicant 3.	❑	❑
Applicant 4.	❑	❑

3. Have you ever been diagnosed with, received treatment, or taken prescription drugs for high blood pressure (you may answer NO only if it has been controlled by the consistent use of a prescription drug for 12 months immediately prior to your date of departure from your province of residence)?

Question 3.	YES	NO
Applicant 1.	❑	❑
Applicant 2.	❑	❑
Applicant 3.	❑	❑
Applicant 4.	❑	❑

If you answered NO to all questions, you are eligible for the Star rates. If you answered NO to question 1, and YES to any condition(s) in either question 2 or question 3, then you are eligible for the Select rates.

Please list all current medications and/or details for any recent or current medical conditions, including any conditions that you answer "yes" to in the Rate Qualification section.

Indicate N/A if no prescription medications are being taken and no medical conditions are present.

Applicant Name	List of all medications	Conditions being treated by medications	Date medication was prescribed & date of any changes

List any other medical conditions, symptoms or surgery you have been diagnosed with, suffered from or treated for in the last 24 months. Including the original date diagnosed, name of medication, date prescribed, and any changes in the condition, symptoms or medications.

D. Physician Information

Applicant # (s) ________ Physician name ________________________________ Phone Number ________________

Applicant # (s) ________ Physician name ________________________________ Phone Number ________________

E. Travel Information

Departure Date (D/M/Y) ________________________________

Effective Date of Emergency Medical Coverage (D/M/Y) ________________________________

Termination Date of Coverage (D/M/Y) ________________________________

Trip length __________ days (when calculating the trip length, include the departure and termination dates)

F. Coordination of Benefits

Do you have a GMS ExtendaPlan®, OmniPlan®, travel plan or group policy? ❑ Yes ❑ No If yes, policy number________________

Do you have coverage with another insurer/credit card for this trip? ❑ Yes ❑ No

If yes, insurer________________________________ Dates of coverage:________________________________

G. Rate Calculation

Applicant	Rate Category: St☆r	Select	Standard	Deductible: $0	$250	Daily rate for deductible x		# of days =		Premium
1.	❑	❑	❑	❑	❑	$ _______	x	______ days	=	$ _________
2.	❑	❑	❑	❑	❑	$ _______	x	______ days	=	$ _________
3.	❑	❑	❑	❑	❑	$ _______	x	______ days	=	$ _________
4.	❑	❑	❑	❑	❑	$ _______	x	______ days	=	$ _________

Total Premium $ _________

H. 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.

I. Declaration

I/We ("I") declare the statements made herein are true and complete and shall form part of the application for coverage. I understand the eligibility requirements and where I was unsure of any of my previous medical conditions as it relates to these requirements, I have verified it with my physician(s). Should any changes in health occur prior to the effective date of this policy, I understand that Group Medical Services must be contacted and the application updated.

I am aware of the requirement for medical conditions to be stable for 180 days prior to the policy effective date. 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 service providers (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 obtained pursuant to clause (b); and/or (b) obtain personal information about me (or any 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 warrant that neither I nor any person herein listed have any additional coverage through any insurer other than the information listed herein. 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, 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 persons(s).

________________________________ ________________________________

Signature of Applicant 1 Date (D/M/Y) Signature of Applicant 2 Date (D/M/Y)

Agency Name________________________________

Representative's Name________________________________ Phone Number ________________

❑ Periodically, GMS may send information to you in order to develop and recommend suitable products and serivces. Check here if you do not wish to receive this information.