

Group Medical Services StudentPlan Application

Agent # 347610

StudentPlan # _____

Name _____ Phone _____

Permanent Address _____ City _____ Prov _____ Postal Code _____

Spouse and Dependents to be Included (If Applicable)

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

School Information

Educational Institution _____

City _____ Province/State _____ Country _____

Have you received a scholarship or waiver of entrance fees? Yes No

If yes - what type? _____

Does it include medical insurance? Yes No

Payment Information

Coverage to Begin(dd/mm/yy) _____ to continue for _____ months until (dd/mm/yy) _____

Single Couple Family Monthly Rate \$ _____ x _____ months = \$ _____

Cash Cheque Visa MasterCard

Credit Card Number _____ Expiry Date _____

Signature of Card Holder _____

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 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 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 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.

X _____ Date _____
Signature of all applicants 18 years of age and older

Group Medical Services #200 – 3303 Hillside Street, Regina SK S4S 7J8 1-800-667-3699



Group Medical Services

StudentPlan Card

Name _____

Effective Date _____

Expiry Date _____

StudentPlan # _____

24-Hour Worldwide Assistance

In the event of a medical emergency, contact our designated travel assistance firm immediately to confirm covered expenses and procedures.

Toll free 1-800-459-6604
(Within Canada & U.S.)

or

Collect (416) 260-4970
(From all other locations)