



A. Applicant Information

First Name _____ Last Name _____

Address _____

City _____ Province _____ Postal Code _____

Phone (_____) _____ Email _____

Applicant #	First Name	Last Name	Health Services Number	Gender	Birthdate
1	APPLICANT			M/F	DD / MM / YYYY
2	CO-APPLICANT			M/F	DD / MM / YYYY
3	DEPENDANT	<input type="checkbox"/> Student*		M/F	DD / MM / YYYY
4	DEPENDANT	<input type="checkbox"/> Student*		M/F	DD / MM / YYYY
5	DEPENDANT	<input type="checkbox"/> Student*		M/F	DD / MM / YYYY
6	DEPENDANT	<input type="checkbox"/> Student*		M/F	DD / MM / YYYY

* Check Student if the Dependant is 18-24 years of age and is undergoing full-time student educational training in the same province as the applicant.

Are any listed Applicants converting from another Group Medical Services Plan? YES NO

If YES, please indicate: Date Previous Coverage Expires/Ends DD / MM / YYYY

Existing GMS customers transferring plans within sixty (60) days of coverage lapse are not required to complete Section D.

Are any listed Applicants converting from another insurer's Group Benefit Plan? YES NO

If YES, please indicate: Previous Insurer _____ Plan # _____ Date Benefits Ended DD / MM / YYYY

If the conversion is within sixty (60) days of coverage lapse, the Applicants will be automatically accepted.

B. Coordination of Benefits

B1. Do any listed Applicants have coverage with another insurer? YES NO (If YES, please complete the section below)

Applicant #	Insurer	Policy Holder	Policy/Certificate #	Coverage (check all that apply)		
				<input type="checkbox"/> Health	<input type="checkbox"/> Drug	<input type="checkbox"/> Vision
				<input type="checkbox"/> Dental	<input type="checkbox"/> Travel	
				<input type="checkbox"/> Health	<input type="checkbox"/> Drug	<input type="checkbox"/> Vision
				<input type="checkbox"/> Dental	<input type="checkbox"/> Travel	
				<input type="checkbox"/> Health	<input type="checkbox"/> Drug	<input type="checkbox"/> Vision
				<input type="checkbox"/> Dental	<input type="checkbox"/> Travel	

Office Use: Agent #1 _____ Agent #2 _____ Split A1% / A2% Effective Date DD / MM / YYYY GMS ID # _____

C. Physician Information

Applicant #	Physician Name	Phone Number (include area code)

D. Medical Information

D1. Health Conditions and Procedures

Has any Applicant consulted a physician or specialist about, suffered from, been diagnosed with, received treatment or taken prescription drugs for any of the following in the past two years? (If YES, please circle the condition(s), and indicate which Applicant #)

Conditions and Procedures	YES/NO	Applicant #
Heart Attack / Congestive Heart Failure / Angina / Irregular Heartbeat / Other Heart Conditions	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Stroke / TIA / Blood Clots	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Aneurysm / Peripheral Vascular Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Home Oxygen Therapy	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Liver Disease / Kidney Disease and/or Failure / Bladder Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Gastrointestinal Disorder / Crohn's / Colitis / IBS	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Cancer / Tumor / Any Terminal Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	
AIDS / HIV	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Arthritis / Rheumatism / Musculoskeletal Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Any other Disease / Disorder / Condition or Physical Impairment? (Please specify in D2 below)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Two or more episodes of Fainting or Falling? (Please specify in D2 below)	<input type="checkbox"/> YES <input type="checkbox"/> NO	

D2. Explanation of Health Conditions

If any Applicant answered YES to any condition in question D1, please explain below.

Applicant #	Condition	Date Diagnosed	Results & Extent of Recovery

D3. Health Practitioners

Has any Applicant, during the past two years, consulted, received advice or treatment or been advised to seek treatment from a chiropractor, physiotherapist, massage therapist, psychologist, podiatrist or acupuncturist?

YES NO (If any Applicant answered YES to the above, please give details below)

Applicant #	Practitioner	Condition	Date Diagnosed	Results & Extent of Recovery

D4. Future Procedures

a) Is any Applicant on a waiting list, scheduled for or otherwise awaiting hospitalization or surgery? YES NO

b) Have any tests or exams been advised by a doctor, but not yet completed? YES NO

(If any Applicant answered YES to either of the above questions, please give details below)

Applicant #	Condition	Type of Treatment	Expected Date of Treatment

E. Prescription Medication

E1. Has any Applicant taken any prescription medication in the past 6 months or have a prescription for which refills are currently authorized? YES NO (If any Applicant answered YES to the above, please give details below)

Applicant #	Prescription Name, Strength & Dosage	Medical Condition	Length of Time Used	Refills Authorized

