Group Medical Services

Pre-Authorized Payment
Application/Change Form

Please complete all sections and return with a void cheque (if not already provided) to GMS Head Office: #200 – 3303 Hillsdale Street, Regina, SK S4S 7J8. The original signed form is required for pre-authorized payment to be authorized.

A. Personal Information

Name of Contract Holder ______________________ Plan Type: ☐ Group Benefit Plan ☐ Individual Health Plan

Name(s) of Bank Account Holder ______________________ Email ______________________

Address ______________________ City ____________ Province ________ Postal Code ________

Business Phone (   ) ______________________ Business Fax (   ) ______________________

B. Account Information

Type of Account:

☐ Chequing — If the account being used is a **chequing account**, **please provide a blank cheque marked "Void."**

☐ Savings — If the account being used is a **savings account, please provide the following information:**

Name of Bank/Financial Institution ______________________

Bank Number ____3 digits____ Transit Number ____5 digits____ Account Number ______________________

Address ______________________ City/Town ______________________ Prov ________ Postal Code ________

Please remember the following when using Pre-Authorized Payments:

- **Payment for the first month's premium amount must be included with this application.**
- NSF withdrawals will be handled in accordance with GMS standard NSF policy
- Withdrawal payments will continue until such time as written notice to the contrary is given.
- We require 30 days notice, in writing, if there is a change to your banking information.

C. Declaration

I/We ("I") hereby authorize the above named financial institution to debit my account for all payments to Group Medical Services for payment of my premiums and any related fees, as may be determined from time to time, and which may be collected monthly in advance.

Each payment will be treated as though I had personally issued a cheque authorizing payment to Group Medical Services as indicated and to debit the amount specified to my/our account.

Any delivery of this authorization to the above financial institution constitutes delivery by me.

This authorization may be cancelled at any time by providing written notice to Group Medical Services. However, I understand that I am responsible for remitting monthly premiums to Group Medical Services, and upon cancellation of this authorization, will ensure that any unpaid premiums are remitted in full immediately.

X ____ DD / MM / YYYY ______________

Signature of Authorized Account Holder (In the case of a joint account, all depositors signatures must appear.) **Date**

For Office Use Only:	GMS ID#:		Date Received:	DD / MM / YYYY

Group Medical Services is the operating name for GMS Insurance Inc. in provinces outside of Saskatchewan.