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Group Medical Services

NSGREA Benefits Program
Enrolment Form

Please remember to include a Pre-Authorized Debit Agreement with this application.

A. Member Information

You must be a member of NSGREA to enrol in this group benefit plan. Are you a member? ❑ Yes ❑ No	Retirement Date *(DD/MM/YYYY)*		
First Name	Last Name	Sex ❑ M ❑ F	
Address	City	Province	Postal Code
Phone ( )	Email		

B. Coverage Selection

Choose Your Plan	Select Your Coverage Type *(select one option)*		
Dental Plan Option 1 ❑	Single ❑	Couple ❑	Family ❑
Dental Plan Option 2 ❑	Single ❑	Couple ❑	Family ❑
Already enrolled in a Dental Plan Option? If you are, you may select the Travel Plan. If you are not, you must select one of the Dental Plan Options above.			
Travel ❑	Single ❑	Couple ❑	Family ❑

C. Applicant Information

Member

First Name	Last Name	Provincial health coverage in place? ❑ Yes ❑ No
Date of Birth *(DD/MM/YYYY)*	Dental coverage with another insurer? ❑ Yes ❑ No *If "Yes", name of insurer and policy number:*	

Spouse

First Name	Last Name	Provincial health coverage in place? ❑ Yes ❑ No
Date of Birth *(DD/MM/YYYY)*	Dental coverage with another insurer? ❑ Yes ❑ No *If "Yes", name of insurer and policy number:*	

Dependant*

First Name	Last Name	Provincial health coverage in place? ❑ Yes ❑ No
Date of Birth *(DD/MM/YYYY)*	Dental coverage with another insurer? ❑ Yes ❑ No *If "Yes", name of insurer and policy number:*	

*For each dependant child age 21 and over:

- in the case of a student dependant, please indicate the educational institution where the child is receiving full-time training:

  ____

- in the case of a dependant due to a developmental or physical disability, please attach or enclose a doctor's note or copy of an equivalent document as evidence.

D. Declaration

I declare that the information given on this form is true and complete and shall form part of my application for coverage. I hereby authorize any health or dental care provider, other person, hospital or institution to release to GMS 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: (a) to store and use any information which I have provided or information which it obtained pursuant to clause (b); and/or (b) to obtain information from, or disclose 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.

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 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.

I understand that I am purchasing an annual plan from Group Medical Services, and upon cancellation of this plan, will ensure that any unpaid annual premium is remitted in full immediately.

Signature of all family members over the age of 18	Date *(DD/MM/YYYY)*
X	

For Office Use Only: Effective Date of Coverage DD / MM / YYYY

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Group Medical Services

Pre-Authorized Debit (PAD) Agreement

Please complete this PAD Agreement and return it, along with payment for the first month's premium, to: *Administration* at *Group Medical Services, 2055 Albert Street PO Box 1949 Regina, SK S4P 0E3*. The original signed form is required for pre-authorized debits to be authorized.

A. General Information

GMS ID No. *(if applicable)*	Group Plan No. *(if applicable)*	Date *(DD/MM/YYYY)*

Please indicate what type of use this PAD Agreement is for:

❑ Business *(I am an employer paying my employee's premium.)*

Employer Name

❑ Personal *(I am an individual paying my own premium.)*

First Name	Last Name

B. Account Information *(please include a void cheque with this agreement)*

Financial Institution Name	Address	
City	Province	Postal Code
Financial Institution Number	Branch Transit Number	Account Number

Type of Account (<u>*only Canadian accounts are acceptable*</u>)

❑ Savings ❑ Chequing

Is this a change to your PAD Agreement information? *If "Yes", please describe the reason for change.*

❑ Yes ❑ No

C. Declaration

I/We ("I") authorize Group Medical Services (GMS), and the financial institution designated to begin deductions as per my/our ("my") instructions for monthly regular recurring payments, and/or one-time payments from time to time, for payment of all charges arising under my GMS account(s). Regular monthly payments for the full amount of services delivered will be debited from my account on the 1st ❑ or 15th ❑ *(choose one date only)*.

I waive my right to receive pre-notification of the amount of the PAD and agree that I do not require advance notice of the amount of PADs before the debit is processed.

This PAD Agreement may be cancelled at any time provided notice is received, in writing, at the address provided above at least 14 days before the next debit is scheduled to be processed. Please contact our office or visit our web site to obtain a cancellation form.

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

Signature of Authorized Account Holder*	Signature of Authorized Account Holder*
X	**X**
Name *(please print)*	Name *(please print)*

**Where Account Holder's account agreement requires the signature of two or more signing authorities, the signatures of all such persons are required for the purposes of this Pre-Authorized Debit Agreement.*

Please remember the following when using Pre-Authorized Debit:

- Payment for the first month's premium amount must be included with this application.
- You may be subject to an administration charge for each monthly withdrawal.
- Non-Sufficient Funds (NSF) withdrawals will be handled in accordance with GMS's standard NSF policy and in accordance with the rules laid out by The Canadian Payments Association (CPA).
- Information on the administration charge and GMS' standard NSF policy can be found on gms.ca.
- Withdrawal payments will continue until such time as written notice to the contrary is given, in accordance to the right of termination of this PAD Agreement.
- Any change to the information provided under this PAD Agreement or to the product or service for which this PAD Agreement is attached will require that a new PAD Agreement be completed, signed and submitted to GMS Head Office along with a void cheque. We require receipt of this new PAD Agreement 14 days before the next debit is scheduled to be processed.