

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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Retirement Date (DD/MM/YYYY)	
First Name	Last Name		Sex <input type="checkbox"/> M <input type="checkbox"/> 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 <input type="checkbox"/>	Single <input type="checkbox"/>	Couple <input type="checkbox"/>	Family <input type="checkbox"/>
Dental Plan Option 2 <input type="checkbox"/>	Single <input type="checkbox"/>	Couple <input type="checkbox"/>	Family <input type="checkbox"/>
<i>Already enrolled in a Dental Plan Option?</i> If you are, you may select the Travel Plan. If you are not, you must select one of the Dental Plan Options above.			
Travel <input type="checkbox"/>	Single <input type="checkbox"/>	Couple <input type="checkbox"/>	Family <input type="checkbox"/>
C. Applicant Information			
Member			
First Name	Last Name	Provincial health coverage in place? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Birth (DD/MM/YYYY)	Dental coverage with another insurer? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", name of insurer and policy number:</i>		
Spouse			
First Name	Last Name	Provincial health coverage in place? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Birth (DD/MM/YYYY)	Dental coverage with another insurer? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", name of insurer and policy number:</i>		
Dependant*			
First Name	Last Name	Provincial health coverage in place? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Birth (DD/MM/YYYY)	Dental coverage with another insurer? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", name of insurer and policy number:</i>		
<p>*For each dependant child age 21 and over:</p> <ul style="list-style-type: none"> 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.

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

