



1 Employee/Member Information					
Last Name		First Name		Initial	Group No. (if applicable)
GMS ID No.	Health Services No.	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth (d/m/y)	Spouse's Date of Birth (d/m/y)	
Address		City/Town	Prov.	Postal Code	Telephone No.
Are any of the claims due to a work-related accident or sickness? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Are any of the claims due to a motor vehicle accident? Yes <input type="checkbox"/> No <input type="checkbox"/>					
2 Other Coverage Information					
Do you, your spouse, or any dependant(s) have coverage under any other insurance plan?					
<input type="checkbox"/> Yes (Please complete below) <input type="checkbox"/> No (Please proceed to Section 3)					
If you have coverage through another insurance plan you must complete this section.					
Name of Insured and Start Date of Coverage	Insurer	Policy #	Certificate #	Coverage <small>Check all that apply</small>	Who is Covered? <small>Choose all that apply</small>
				<input type="checkbox"/> Health <input type="checkbox"/> Vision <input type="checkbox"/> Drugs <input type="checkbox"/> Travel <input type="checkbox"/> Dental	<input type="checkbox"/> Myself <input type="checkbox"/> My spouse <input type="checkbox"/> My children
				<input type="checkbox"/> Health <input type="checkbox"/> Vision <input type="checkbox"/> Drugs <input type="checkbox"/> Travel <input type="checkbox"/> Dental	<input type="checkbox"/> Myself <input type="checkbox"/> My spouse <input type="checkbox"/> My children
				<input type="checkbox"/> Health <input type="checkbox"/> Vision <input type="checkbox"/> Drugs <input type="checkbox"/> Travel <input type="checkbox"/> Dental	<input type="checkbox"/> Myself <input type="checkbox"/> My spouse <input type="checkbox"/> My children
				<input type="checkbox"/> Health <input type="checkbox"/> Vision <input type="checkbox"/> Drugs <input type="checkbox"/> Travel <input type="checkbox"/> Dental	<input type="checkbox"/> Myself <input type="checkbox"/> My spouse <input type="checkbox"/> My children
3 Claims Information (If submitting a dental claim please attach a Standard Dental Claim Form completed by your dentist's office.)					
First Name	GMS ID No.	Date of Birth (d/m/y)	Type of Expense (e.g. Ambulance, Crutches, etc)	No. of Claims	Total Amount of Claims
Total					

Please remember the following when submitting claims:

- All claims must be submitted within twelve (12) months from the date of service.
- Submit only original itemized receipts. Attach all receipts to this claim form.
- GMS Insurance Inc. does not return receipts; keep a photocopy of the receipt if necessary.
- Include any required physician referrals or orders.
- Please accumulate \$20 in total expenses before submitting a claim

...See Over



4 Declaration

I/We declare the statements made herein are true and complete. For the purpose of administering any GMS Insurance Inc. benefits, products or services (collectively "benefits") and/or determining eligibility for benefits, I authorize GMS Insurance Inc. (including, without limitation Group Medical Services and its subsidiary GMS Insurance Inc.) to: (a) collect, store and use any personal information which I have provided or personal information obtained pursuant to clause (b); and/or (b) obtain personal information 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. I hereby authorize GMS Insurance Inc. to coordinate any eligible expenses with any additional insurer that I or any person herein listed may have coverage under.

Signature of all claimants over eighteen

Date

Claims Payment Authorization (Optional)

I/We, _____, authorize GMS Insurance Inc. to:

- make this/these claim reimbursements payable to _____, who is an adult member of my family's extended health care plan.
- make this/these and all future claim reimbursements payable to _____, who is an adult member of my family's extended health care plan. This authorization shall remain in force until GMS Insurance Inc. is notified, in writing, otherwise.

Signature of all claimants over eighteen.

Note: If no election is made, payment will be made according to the instructions we have on file. If we have no instructions on file, payment will be made directly to each claimant, if 18 or over, or to the employee if the claimant (s) is/are 17 or under.

To help protect your privacy GMS Insurance Inc. does not share your personal health information with anyone, other than yourself. If you wish GMS Insurance Inc. to share your personal health information with someone other than yourself please contact our office for an Information Authorization Form.

Claims can be mailed to, or dropped off at, GMS Insurance Inc.'s head office:

Attn: Group Claims
#200 – 3303 Hillside Street
Regina, SK S4S 7J8