

1 Applicant Information

Please Check One: New Applicant Revision to Present Plan

Name of Employer:

Mailing Address: (in full)

Street

City

Province

Postal Code

Business Location: (if different from above)

Street

City

Province

Postal Code

Telephone Number:

Fax Number:

Legal Status:

Corporation

Partnership

Proprietorship

Other

Association

Nature of Employer's Business:

Date Established:

Group Administrator:

Name

Title

Telephone Number

Fax Number

Email

2 Eligibility/Coverage

Eligible Classes of Employees

Number of
Employees

Number of
Employees

**Waiting period for new employees hired
after effective date of insurance**

3 months

Permanent full-time

Contract/Seasonal

Permanent part-time

Other, please specify

Coverage	Please Indicate:			
Extended Health Care	OPTIONAL		<input type="radio"/> Yes	<input type="radio"/> No
Dental Care	OPTIONAL		<input type="radio"/> Yes	<input type="radio"/> No
Life	MANDATORY			
AD&D	MANDATORY			
Dependent Life	MANDATORY			
Weekly Indemnity	OPTIONAL		<input type="radio"/> Yes	<input type="radio"/> No
Long Term Disability	MANDATORY			
ASO	OPTIONAL		<input type="radio"/> Yes	<input type="radio"/> No
Cost Plus*	OPTIONAL		<input type="radio"/> Yes	<input type="radio"/> No

*Cost Plus can only be selected in addition to the Extended Health and/or Dental Care or ASO optional coverages

3 Broker Information:

Broker 1: ___ TSG Financial _____

Commission _____%

Broker 2: _____ Code: _____

Commission _____%

4 General Information

Are any employees or dependents currently hospital confined or otherwise disabled or handicapped? Yes No
If yes, please list the names:

Is this plan to be in addition to any other group life and/or health presently in force? Yes No

Is this plan intended to replace any existing coverage? Yes No If YES, please complete this section.

Benefit	Name of Current Carrier	Effective Date of Present Coverage	Number of Carriers in the Last 3 Years
Extended Health Care	_____	_____	_____
Dental Care	_____	_____	_____
Life	_____	_____	_____
AD&D	_____	_____	_____
Optional Life	_____	_____	_____
Optional AD&D	_____	_____	_____
Dependent Life	_____	_____	_____
Weekly Indemnity	_____	_____	_____
Long Term Disability	_____	_____	_____

Premium Contributions:

	Employer %	Employee %		Employer %	Employee %
Extended Health Care	_____	_____	Dependent Life	_____	_____
Dental Care	_____	_____	Weekly Indemnity	_____	_____
Life/AD&D	_____	_____	Long Term Disability	_____	_____

Premium Payment Option:

Pre-authorized Payment is required (complete the following section)

Monthly Pre-Authorized Payment (PAP) Terms: I/We ("I") hereby authorize my financial institution to debit my/our account for all payments to GMS for payment of my/our premiums and any related fees, as may be determined from time to time, and which will be collected monthly in advance. Each payment will be treated as though I had personally issued a cheque authorizing payment to GMS for services as indicated and to debit the amount specified to my/our account. This authorization may be cancelled by providing 30 days written notice to GMS, and upon cancellation of this authorization, will ensure that any unpaid premiums are remitted in full immediately. NSF withdrawals will be handled in accordance with GMS standard NSF policy.

I agree to the Monthly PAP Terms above. If two signatures are required on a cheque, all signing officers must sign.

Signature(s) 5 _____ 5 _____

PAYMENT FOR THE FIRST MONTH'S PREMIUM AMOUNT MUST BE INCLUDED WITH THIS APPLICATION. ATTACH A BLANK CHEQUE MARKED "VOID."

Requested effective date of this plan: 1st day of _____, 2 _____

5 Declaration

The applicant hereby declares that, to the best of the applicant's knowledge, the statements and answers contained herein are full, complete and true as of the date hereof and expressly agrees that (1) such statements and answers shall constitute the application for the contract and form part of the contract, and (2) the coverage shall become effective in accordance with and subject to the policy to be issued to the applicant but in no case shall it become effective until this application has been approved by GMS. Group Medical Services will not be liable to the applicant or to any of the applicant's employees until the application is approved. The applicant understands that the Life, AD&D, Dependent Life, Weekly Indemnity and Long Term Disability are provided by The Co-operators Life Insurance Company (the "Co-operators") and that GMS acts only as the administrative agent for the Co-operators in placing and administering such coverage. The Co-operators and not GMS has the authority and responsibility for assessing and approving your application for such coverage and any claims made thereunder. As such, any policy providing such coverage, if approved by the Co-operators, will be a contract with the Co-operators and the information you have supplied in this application will be provided to and relied on by the Co-operators and included as part of that contract. The undersigned declares that he/she has authority to sign on behalf of the applicant and understands that, whether before or after the date of application, any misrepresentation, incorrect or concealed information or failure to fully complete all sections of the application may void the coverage.

Do not terminate any existing coverage until notice has been given in writing that the coverage being applied for is approved by Group Medical Services.

Dated at _____ this _____ day of _____,

by _____ (signature) _____ (Print Name & Title)