



**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

Full names of Branch Affiliates or Subsidiaries that are to be included (all under one bill).

Affiliated	Subsidiary	Name and addresses:	# of employees
<input type="radio"/>	<input type="radio"/>	_____	_____
<input type="radio"/>	<input type="radio"/>	_____	_____
<input type="radio"/>	<input type="radio"/>	_____	_____

Nature of Employer's Business:

Date Established:

**Group Administrator:**

Name

Title

Telephone Number

Fax Number

Email

**2 Eligibility/Coverage**

**Eligible Classes of Employees**

<input type="radio"/> Permanent full-time	Number of Employees _____	<input type="radio"/> Contract/Seasonal	Number of Employees _____
<input type="radio"/> Permanent part-time		<input type="radio"/> Other, please specify	

Coverage					Rates	
Extended Health Care	<input type="radio"/> Option 1	<input type="radio"/> Option 2	<input type="radio"/> Option 3	<input type="radio"/> Other (see attached)	Single _____	Family _____
Dental Care (Max. \$ _____)	<input type="radio"/> Option 1	<input type="radio"/> Option 2	<input type="radio"/> Option 3	<input type="radio"/> Other (see attached)	Single _____	Family _____
Life	<input type="radio"/> Yes	<input type="radio"/> No			Cost per \$1,000 _____	
AD&D	<input type="radio"/> Yes	<input type="radio"/> No			Cost per \$1,000 _____	
Dependent Life	<input type="radio"/> Yes	<input type="radio"/> No			Cost per Life _____	
Weekly Indemnity	<input type="radio"/> Yes	<input type="radio"/> No			Cost per \$10 _____	
Long Term Disability	<input type="radio"/> Yes	<input type="radio"/> No			Cost per \$100 _____	

### 3 General Information

Are any employee's 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 %
<b>Extended Health Care</b>	_____	_____	<b>Dependent Life</b>	_____	_____
<b>Dental Care</b>	_____	_____	<b>Weekly Indemnity</b>	_____	_____
<b>Life/AD&amp;D</b>	_____	_____	<b>Long Term Disability</b>	_____	_____

Choose one the following payment options:  EFT  Cheque

Requested effective date of this plan:

### 4 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 Insurance Inc. GMS Insurance Inc. 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 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 GMS Insurance Inc.**

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

by \_\_\_\_\_ (Applicant's signature) \_\_\_\_\_ (Title)

\_\_\_\_\_ (Applicant's Printed Name)

For Office Use Only:

\_\_\_\_\_  
Agent

\_\_\_\_\_  
Approved By