



#200 – 3303 Hillside Street • Regina, Saskatchewan • S4S 7J8 • Phone 1-800-667-3699 **DO NOT FAX – ORIGINAL REQUIRED**

Important Information – Please complete and return this form to your Group Administrator

1 General

To be completed by the Employer.

Company			
Employee's Occupation	Class	Regular hrs/week	Annual Earnings

2 Plan Member/Employee Information

Employee Name (last, first, middle initial)	Date of Birth (dd/mm/yy)	Gender (M/F)	Provincial Health Care Coverage in Place? <input type="radio"/> Yes <input type="radio"/> No
Home Address	City/Town	Province	Postal Code
			Telephone Number

3 New/Reactivated or Changing Information

Are you a new employee re-hire changing information (if you are changing information proceed to Step 4)

Provide permanent full time hire date Date (dd/mm/yy) Coverage effective date Date (dd/mm/yy)

If a re-hire, provide the date previous employment ended Date (dd/mm/yy) and re-hire date Date (dd/mm/yy)

4 Family Information (Initial Application or Changing Information)

(If you have a change to your Co-ordination of Benefits please complete section 5)

Type code I/A/C/D (see below)	Effective date (dd/mm/yy)	Spouse/child name Include last name if different from yours (last, first, middle initial)	Date of birth ** (dd/mm/yy)	Gender (M/F)	Provincial Health Care Coverage in Place?	Full - time student?*
		Spouse (if common-law see below)			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
		Child			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
		Child			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
		Child			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
		Child			<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

Change type codes: I = Initial Application, A = Add, C = Change, D = Delete

* Indicate educational institution for full time students: _____

**If a dependent child is over the age of twenty-five (25), please provide proof of disability.

If your spouse is common-law the following must be completed: I have been living with and representing the above as my spouse since _____ (dd/mm/yy). My common-law spouse and I are responsible financially for all our children claimed for insurance purposes. I further verify that I am not obliged to provide coverage for my legal spouse.

For Office Use Only:	GMS ID #	Group #	Coverage Effective Date
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5 Co-ordination of Benefits (COB)

Do you or any persons listed in section 4 have other coverage with another insurer? Yes (please complete the section below) No

Name of Insured	Insurer	Policy #	Certificate #	Coverage Check all that apply		Who's Covered? Choose all that apply
				<input type="radio"/> Health <input type="radio"/> Drugs <input type="radio"/> Dental	<input type="radio"/> Vision <input type="radio"/> Travel	<input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My children
				<input type="radio"/> Health <input type="radio"/> Drugs <input type="radio"/> Dental	<input type="radio"/> Vision <input type="radio"/> Travel	<input type="radio"/> Myself <input type="radio"/> My spouse <input type="radio"/> My children

If there are more than two insurers, please attach a separate sheet.

6 Beneficiary Designation

Life Beneficiary:

Full Name of Beneficiaries	Relationship	% Share

If a designated beneficiary is a minor I appoint _____ as a Trustee.

Your beneficiary designation will not be revoked or changed automatically by any future marriage or divorce. If you wish to change your beneficiary you will have to make a new designation below.


Life Beneficiary Change (Note: The effective date of the Beneficiary change will be the date this form is signed.)

Change of name only Change of beneficiary Relationship to Plan Member _____

Name of beneficiary (last, first, middle initial) _____

Signature of previous irrevocable beneficiary _____

I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of 18.

Coverage is provided by  *the co-operators* for Life, AD&D, Dependent Life, Weekly Indemnity and Long Term Disability.

7 Refusal of Benefits

I have been given the opportunity to apply for coverage but do not wish to participate, and understand that I will not be able to enroll in these plans at a later date without the mutual consent of my employer and GMS Insurance Inc.

Waive Health Waive Dental Waive both Reason _____

Signature _____ Date _____

8 Plan Member/Employee Signature

I/We ("I") declare the statements made herein are true and complete and shall form part of my application for coverage. I hereby authorize any physician, health care provider, other person, hospital or institution to release to GMS Insurance Inc. 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 to: (a) collect, store and use any information which I have provided or information obtained pursuant to clause (b); and/or (b) obtain information from, or disclose 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 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 understand 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.

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 co-ordinate any eligible expenses with any additional insurer that I or any person herein listed may have coverage under.

Signature _____ Witness _____ Date _____
(if designating or changing beneficiary)