PERSONAL HEALTH COVERAGE
Upgrade Form

BROKER/AGENT: Please complete the designated section at the end of this application to confirm proper disclosure has been made to the client.

Any changes made will apply to all insured individuals on your plan. Downgrading a plan is only permitted at renewal. Removing additional coverage can only be completed at renewal and the option must have been in place for a minimum of 12 months. Depending on your province of residence the premium charged may be subject to tax. Please contact info@gms.ca for further information about downgrading your plan or removing additional coverage.

A. Applicant Information *(Please complete this section in full.)*

First Name		Last Name	GMS ID No.
Date of Birth *(DD/MM/YYYY)*	Phone ( )	Email	❑ *Yes, I would like to receive email about special offers, promotions and opportunities to provide feedback about GMS products and services.*

B. Coverage Upgrade *(Complete B1. to upgrade a current plan and B2. to add or modify additional coverage options.)*

❑ B1. Upgrade Plan *(Please complete Section C.)*

Select Current Plan Type:	Select New Plan Type:
❑ BasicPlan ❑ ExtendaPlan®	❑ ExtendaPlan ❑ OmniPlan®

❑ B2. Add or Modify Additional Coverage

Select the coverage option(s) you want to add to your plan or upgrade:

- ❑ Basic Prescription Drug – *you must complete Section C4. (Prescription Drug Use) to add this coverage.*
- ❑ Enhanced Prescription Drug – *you must complete Section C4. (Prescription Drug Use) to add or upgrade to this coverage.*
- ❑ Hospital Cash – *you must complete Section C. (Medical Information) to add this coverage.*
- ❑ Dental Care – *no additional medical information required. Proceed to Section D.*
- ❑ Annual Travel - *you must complete Section C. (Medical Information) to add this coverage. If you're increasing your trip length, no additional information is required. Proceed to Section D.* *Select maximum trip length:* ❑ 15 Days ❑ 30 Days ❑ 48 Days

C. Medical Information

C1. Health Conditions

In the past two years, has anyone on this application consulted a physician or specialist about, suffered from, been diagnosed with, received treatment or taken prescription drugs for any of the following conditions? *(Select all that apply and provide details)*

Heart attack / congestive heart failure / angina / irregular heartbeat / other heart conditions	❑ Yes ❑ No
Stroke / TIA / blood clots	❑ Yes ❑ No
Aneurysm / peripheral vascular disease / other vascular condition	❑ Yes ❑ No
Home oxygen therapy / COPD / other lung condition excluding asthma	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No
Liver disease / kidney disease and/or failure / bladder disorder	❑ Yes ❑ No
Gastrointestinal disorder / Crohn's / colitis / IBS	❑ Yes ❑ No
Cancer / tumour / any terminal disease	❑ Yes ❑ No
AIDS / HIV	❑ Yes ❑ No
Arthritis / rheumatism / musculoskeletal disorder / other bone, joint or muscle condition	❑ Yes ❑ No
Any other disease / disorder / condition or physical impairment *(Please specify below)*	❑ Yes ❑ No
Two or more episodes of fainting or falling? *(Please specify below)*	❑ Yes ❑ No

If anyone answered "Yes" to any condition listed about, please explain below.

First Name	Medical Condition	Date Diagnosed *(DD/MM/YYYY)*	Date of last change in treatment *(DD/MM/YYYY)*	Treatment received or expected

C2. Health Practitioners

In the past two years, has anyone applying for an upgrade consulted, received treatment or been advised to seek treatment from a chiropractor, physiotherapist, massage therapist, psychologist, podiatrist, or acupuncturist? ❑ Yes ❑ No

First Name	Practitioner	Medical Condition	Number of visits in the last 2 years	Prognoses for recovery

C3. Future Procedures

a) Is anyone on the application on a waiting list, scheduled for or awaiting hospitalization or surgery? ❑ Yes ❑ No

b) Have any tests or exams been advised by a doctor, but not yet completed? ❑ Yes ❑ No

First Name	Medical Condition	Type of Treatment	Expected Date of Treatment *(DD/MM/YYYY)*

C4. Prescription Drug Use

In the past six months, has anyone applying for an upgrade been prescribed drugs? ❑ Yes ❑ No

First Name	Drug Identification Number (DIN) or Prescription Name and dosage	Medical Condition	Length of Time Used	Authorized Refills
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No

** Please attach a separate sheet for additional information.*

D. Annual Payment Option *(Complete if you pay your premium annually)*

D1. Rate Calculation

Rates will be calculated by GMS at the time the request is processed and based on the effective date chosen. Changes made during the policy period will be prorated based on the remaining months before your plan expires. Changes may be subject to medical rating based on the information provided in Section D. GMS will provide confirmation that your change request has been processed, including the additional premium owed, and the effective date of the change. For a quote prior to submitting your request please contact info@gms.ca.

NOTE: If the premium amounts below are left blank, or show a different amount owed than calculated by GMS, GMS will contact the policyholder to confirm the difference owing and the new annual premium prior to processing payment.

Current Annual Premium	New Annual Premium	Difference Owed
$	$	$

D2. Effective Date of Change(s) *(The effective date chosen must be in the future.)*

❑ Please make the change(s) effective _____*(DD/MM/YYYY)*; or

❑ Please make the change(s) effective on my renewal date.

D3. Payment Details

Payment Amount *(From Difference Owed in E1.)*

$ ❑ Cash ❑ Cheque ❑ Visa ❑ MasterCard

Credit Card Number	Expiry Date *(MM/YY)*	Signature of Cardholder
		X

E. Monthly Payment Option *(Complete if you pay your premium monthly)*

If there has been a change in your financial institution or your banking information, please attach a void cheque to this change form.

E1. Rate Calculation

Rates will be calculated by GMS at the time the request is processed and based on the effective date chosen. Changes may be subject to a medical rating based on the information provided in Section D. GMS will provide confirmation that your change request has been processed, including the new monthly payment amount, and the effective date of the change. For a quote prior to submitting your request please contact info@gms.ca.

NOTE: If the new monthly premium amount below is left blank, or GMS calculates a different new monthly premium than the amount shown, GMS will contact the policyholder to confirm the new monthly premium owing prior to processing payment.

Current Monthly Premium	New Monthly Premium
$	$

E2. Effective Date of Change(s)

- ❑ Please make the change(s) effective on my next scheduled pre-authorized withdrawal date.
  Note: GMS must be notified at least 10 business days in advance in order to process the change(s) so they are effective on your next scheduled withdrawal date. Less than 10 business days notice will result in the change(s) being effective on the following pre-authorized withdrawal date.
- ❑ Please make the change(s) effective on my renewal date.

E3. Update to Monthly Pre-Authorized Debit (PAD) Amount

I/We ("I") authorize Group Medical Services (GMS), and the financial institution designated to continue deductions as per my/our ("my") instructions for monthly regular recurring payments, and/or one-time payments from time to time, for payment of all charges arising under my GMS account(s). Regular monthly payments for the full amount of services delivered will continue to be debited from my account on my regular scheduled withdrawal date.

I waive my right to receive pre-notification of the amount of the PAD and agree that I do not require advance notice of the amount of PADs before the debit is pro-cessed.

This PAD Agreement may be cancelled at any time provided notice is received, in writing, at the address provided below at least 10 business days before the next debit is scheduled to be processed. Please contact our office or visit our website to obtain a cancellation form.

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

Signature of Authorized Account Holder*	Signature of Authorized Account Holder*
X	**X**
Name *(please print)*	Name *(please print)*

** Where account holder's account agreement requires the signature of two or more signing authorities, the signatures of all such persons are required for the purposes of this Pre-Authorized Debit Agreement.*

F. Applicant Declaration

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 Group Medical Services and/or its authorized agents, representatives, affiliates or other service providers (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 personal information which I have provided to GMS or personal information obtained pursuant to clause (b); and/or

(b) obtain personal information about me (or any other person listed herein) from, or disclose such personal information to: my government health 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 for the purposes described above.

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) listed herein and confirm that each of the above declarations and authorizations are also provided on behalf of such person(s).

Applicant's signature	Date *(DD/MM/YYYY)*
X	

G. For Broker or agent use only

The undersigned hereby confirms that appropriate disclosure, as set out in the Canadian Council of Insurance Regulators: Advisor Disclosure document, has been made to the client regarding: (a) the company or companies represented; (b) that a commission is received for sale of this insurance product; (c) that additional compensation may be received in the form of bonuses; (d) any conflict of interest with respect to this transaction.

Agent Signature **X** _____

Agent #1 | Agent #2 | Split A1% / A2% | For Office Use: | Effective Date: DD/MM/YYYY | GMS ID: