



VTC #

A. Applicant Information

New Coverage OR Extension to Existing Coverage If extension, original arrival date in Canada DD/MM/YYYY

Table with 6 columns: \*Applicant #, First Name, Last Name, Gender, Birthdate, Age. Rows 1-6.

Canadian Address City Province Postal Code
Country of Origin Email
Name of Local Emergency Contact Emergency Contact Phone #

B. Eligibility Requirements

Please answer the following questions to determine if you are eligible for coverage:

- 1) Have you been in Canada for more than thirty (30) days?
2) Are you eighty (80) years of age or older as of the application date?
3) Have you had a medical consultation with a physician since you arrived in Canada?
4) Do you have a reason to seek medical attention when you apply?
5) If, on the effective date of your application; you are fifty-five (55) years or older and in the past twelve months:
a) have you suffered from, been diagnosed with, received new treatment for, or had a recurrence of, or complications relating to any of the following: stroke/TIA, blood clots, congestive heart failure, atrial/ventricular fibrillation, AIDS, any terminal illness, renal failure or gastrointestinal bleeding?
b) have you undergone the following procedures: renal dialysis, valve replacement or organ transplant?
c) Are you awaiting further tests or treatment for heart disease?
d) Do you have both heart disease and insulin dependent diabetes and are you taking prescription medication for both?
e) Do you use home oxygen for a heart and/or lung disease?
f) Do you take oral steroids for a lung condition?
g) Do any of the following apply to you: you are under active treatment for cancer, have an aortic aneurysm that remains surgically untreated, or have experienced undiagnosed episodes of syncope/fainting or falling?
h) Do you have an ICD (Implantable Cardioverter Defibrillator)?

If you answer YES to any of the above questions, you are NOT eligible to purchase this plan.

I hereby warrant that I AM eligible to purchase this plan (please check the box to confirm eligibility):

Applicant #1 Applicant #2 Applicant #3 Applicant #4 Applicant #5 Applicant #6

## C. Travel Information

### Maximum Coverage Length:

- The maximum number of days of coverage for applicants fifty-four (54) years of age and under is 365 days.
- The maximum number of days of coverage for applicants fifty-five (55) years of age and over is 180 days.

### Important information regarding an Extension of coverage application:

- Your total time of coverage (including original application, any previous extensions and the extension you are now applying for) can not exceed the maximum number of days of coverage noted above;
- Your request for extension must be made to GMS forty-eight (48) hours or more prior to the expiry date of your existing coverage;
- You have not required medical services in excess of \$500 during your existing coverage.

Effective Date of Coverage DD / MM / YYYY Expiry Date of Coverage DD / MM / YYYY

Length of Coverage (# of Days) \_\_\_\_\_ (Include the effective date and expiry date when calculating length of coverage)

## D. Premium Calculation

Daily Rates (per person with a \$1,000 deductible)

Age	Sum Insured			
	\$25,000	\$50,000	\$100,000	\$150,000
Under 55	\$1.43	\$1.76	\$2.76	\$2.92
55-59	\$1.76	\$2.04	\$3.31	\$3.58
60-64	\$2.76	\$3.31	\$3.86	\$4.30
65-69	\$2.98	\$3.58	\$4.80	\$5.40
70-74	\$3.64	\$4.24	\$5.18	\$6.12
75-79	\$3.80	\$4.58	\$5.46	\$6.84

### When calculating rates for alternate deductible Amounts:

**\$1,000 Deductible:** Included in the Daily Rate, no additional calculation

**\$500 Deductible:** Add 15% to the Daily Rate

**\$100 Deductible:** Add 30% to the Daily Rate

**\$0 Deductible:** Add 45% to the Daily Rate

**Note:** Coverage will be effective upon Group Medical Services approval of the application and receipt of the appropriate premium. Coverage will be governed by the terms and conditions described in the policy.

Applicant #	Deductible				Daily Rate for Deductible	# of Days (from Section C)	Premium
1	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$500	<input type="checkbox"/> \$100	<input type="checkbox"/> \$0	\$ _____	X _____	= \$ _____
2	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$500	<input type="checkbox"/> \$100	<input type="checkbox"/> \$0	\$ _____	X _____	= \$ _____
3	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$500	<input type="checkbox"/> \$100	<input type="checkbox"/> \$0	\$ _____	X _____	= \$ _____
4	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$500	<input type="checkbox"/> \$100	<input type="checkbox"/> \$0	\$ _____	X _____	= \$ _____
5	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$500	<input type="checkbox"/> \$100	<input type="checkbox"/> \$0	\$ _____	X _____	= \$ _____
6	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$500	<input type="checkbox"/> \$100	<input type="checkbox"/> \$0	\$ _____	X _____	= \$ _____

Total Premium \$ \_\_\_\_\_

## E. Payment Options

Payment Method:  Cash  Cheque  Visa  MasterCard Credit Card # \_\_\_\_\_ Expiry Date MM / YY

Signature of Cardholder **X** \_\_\_\_\_

## F. 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 Group Medical Services ("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 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 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).

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 coordinate any eligible expenses with any additional insurer that I, or any person herein listed, may have coverage under.

**X** \_\_\_\_\_ DD / MM / YYYY **X** \_\_\_\_\_ DD / MM / YYYY  
Signature of Applicant #1 Date Signature of Applicant #2 Date