

Please complete and return this form to Saskatchewan Retirees Association Inc., Walter Scott Building, 3085 Albert Street, Regina, SK, S4S 0B1

A. Retiree Information				
Are You a Member of the SRA? <input type="checkbox"/> Yes (please provide a copy of your SRA Membership Card) <input type="checkbox"/> No (please complete and enclose an SRA Membership Application)				
First Name	Last Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (DD/MM/YYYY)	
Address		City	Province	Postal Code
Phone ()	Email		Provincial Health Care Coverage in Place? <input type="checkbox"/> Yes <input type="checkbox"/> No	

B. Coverage Selection				
Extended Health <input type="checkbox"/>	<input type="checkbox"/> Single \$86.97/month	<input type="checkbox"/> Couple \$173.22/month	<input type="checkbox"/> Family \$206.13/month	
<i>Already have Extended Health Coverage?</i> If you do, you may select Dental Coverage. If you do not, you must select Extended Health Coverage above.				
Dental <input type="checkbox"/>	<input type="checkbox"/> Single \$38.76/month	<input type="checkbox"/> Couple \$77.49/month	<input type="checkbox"/> Family \$89.14/month	
Start Date of Plan (must be within 60 days of retirement) _____ 1st, 20_____				

Premium charged may be subject to tax.

(Rates effective July 1, 2020 - June 30, 2021)

C. Family Information						
	First Name	Last (if different from yours)	Sex	Date of Birth (DD/MM/YYYY)	Provincial Health Care Coverage in Place?	Dependant age 21 or over? ²
Spouse¹			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A
Dependant			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependant			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependant			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

¹ If your spouse is common-law, please complete the following:

I have been living with and representing the above as my spouse since _____ (DD/MM/YYYY). My common-law spouse and I are financially responsible for all our dependants claimed for insurance purposes. I further verify that I am not obligated to provide coverage for my legal spouse.

² For each dependant age 21 and over:

- in the case of a student dependant under age 25, please indicate the educational institution where the child is receiving full-time training:

- in the case of a dependant due to a developmental or physical disability, please attach or enclose a doctor's note or copy of an equivalent document as evidence.

continued...

For Office Use Only: GMS ID No. _____	Group No. _____	Coverage Effective Date _____
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D. Other Coverage Information

Are you, your spouse or dependant(s) covered by any other insurance plan?

Yes (please complete the following) No (please skip to E)

1	Name of Insured		Start Date of Coverage		End Date of Coverage (if applicable)
	Insurer	Policy No.	Certificate No.	Plan Type <input type="checkbox"/> Group (i.e. employer-sponsored) <input type="checkbox"/> Individual	
	Coverage (check all that apply) <input type="checkbox"/> Health <input type="checkbox"/> Drugs <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Travel			Who Is Covered? (check all that apply) <input type="checkbox"/> Me <input type="checkbox"/> Spouse <input type="checkbox"/> Dependants	
2	Name of Insured		Start Date of Coverage		End Date of Coverage (if applicable)
	Insurer	Policy No.	Certificate No.	Plan Type <input type="checkbox"/> Group (i.e. employer-sponsored) <input type="checkbox"/> Individual	
	Coverage (check all that apply) <input type="checkbox"/> Health <input type="checkbox"/> Drugs <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Travel			Who Is Covered? (check all that apply) <input type="checkbox"/> Me <input type="checkbox"/> Spouse <input type="checkbox"/> Dependants	

E. Declaration

I declare that the information given on this form is true and complete and shall form part of my application for coverage. I hereby authorize any health or dental care provider, other person, hospital or institution to release to GMS 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: (a) to store and use any information which I have provided or information which it obtained pursuant to clause (b); and/or (b) to obtain information from, or disclose information to: my Government Health Insurance Plan; the operator of any hospital, clinic or other health care 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 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.

Signature of Person Enrolling

Date (DD/MM/YYYY)

X

Please remember to include a Pre-Authorized Debit Agreement with this enrolment if you will be paying your premium through a monthly pre-authorized debit.

