gms

SASKATCHEWAN RETIREES ASSOCIATION
Health and Dental Plans Enrolment Form

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

A. Retiree Information

Retirement Date (DD/MM/YYYY)

Effective Date (DD/MM/YYYY) *(Must be within 60 days of retirement. Enrolment must be received within 60 days of retirement to guarantee eligibility.)*

Are You a Member of the SRA?
❑ Yes ❑ No *(please complete and enclose an SRA Membership Application)*

First Name	Last Name	Sex ❑ M ❑ F	Date of Birth *(DD/MM/YYYY)*

Address	City	Province	Postal Code

Phone ( )	Email	Provincial Health Care Coverage in Place? ❑ Yes ❑ No

B. Coverage Selection

Extended Health			
❑ With $1,700 Drug max	❑ **Single** $124.41/month	❑ **Couple** $247.86/month	❑ **Family** $294.63/month
❑ With $2,500 Drug max	❑ **Single** $159.17/month	❑ **Couple** $317.54/month	❑ **Family** $377.44/month
❑ With $3,500 Drug max	❑ **Single** $214.31/month	❑ **Couple** $428.07/month	❑ **Family** $508.79/month

Already have Extended Health Coverage? If you do, you may select Dental Coverage. If you do not, you must select Extended Health Coverage above.

Dental			
❑ $1,200 max	❑ **Single** $51.61/month	❑ **Couple** $103.17/month	❑ **Family** $118.66/month
❑ $2,000 max	❑ **Single** $87.74/month	❑ **Couple** $175.39/month	❑ **Family** $201.72/month

Premium charged may be subject to tax.

(Rates effective July 1, 2025 - June 30, 2026

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]**
Spouse[1]			❑ M ❑ F		❑ Yes ❑ No	N/A
Dependant			❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No
Dependant			❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ No
Dependant			❑ M ❑ F		❑ Yes ❑ No	❑ Yes ❑ 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.

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

continued...

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 ❑ Group *(i.e. employer-sponsored)* ❑ Individual
	Coverage *(check all that apply)* ❑ Health ❑ Drugs ❑ Dental ❑ Vision ❑ Travel		Who Is Covered? *(check all that apply)* ❑ Me ❑ Spouse ❑ Dependants	
2	Name of Insured		Start Date of Coverage	End Date of Coverage *(if applicable)*
	Insurer	Policy No.	Certificate No.	Plan Type ❑ Group *(i.e. employer-sponsored)* ❑ Individual
	Coverage *(check all that apply)* ❑ Health ❑ Drugs ❑ Dental ❑ Vision ❑ Travel		Who Is Covered? *(check all that apply)* ❑ Me ❑ Spouse ❑ 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 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.

Signature of Member	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.

PRE-AUTHORIZATION DEBIT (PAD)
Agreement

Please complete this PAD Agreement and return it to: *Administration* at *Group Medical Services, 2055 Albert Street PO Box 1949 Regina, SK S4P 0E3.*
The original signed form is required for pre-authorized debits to be authorized.

A. General Information

Please indicate what type of use this PAD Agreement is for:

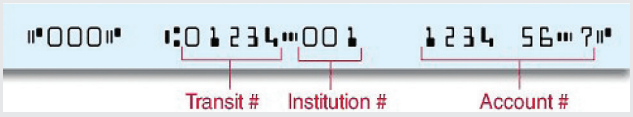
First Name	Last Name	Date of Birth *(MM/DD/YYYY)*

B. Account Information

Financial Institution Name	Address	
City	Province	Postal Code

Please include a void cheque with this agreement.

GMS Health Insurance requires the first months premium payment. The options to pay are: credit card (over the phone), cheque or providing pre-authorized debit information below.



Branch Transit Number	Financial Institution ID Number	Account Number
☐☐☐☐☐	☐☐☐	☐☐☐☐☐☐☐☐☐☐☐☐

Type of Account *(only Canadian accounts are acceptable)*	I authorize regular monthly payments for the full amount of my insurance premiums to be debited from my account on the 1st of each month. ❑	I want to use this same account for claim payments for myself and family members covered under the plan.
❑ Savings ❑ Chequing		❑ Yes ❑ No *(if not, please contact us to set up account)*

C. Declaration

I/We ("I") authorize Group Medical Services (GMS), and the financial institution designated to begin deductions as per my/our ("my") instructions for monthly regular recurring payments and/or one-time payments following notification by written notice, for all charges arising under my GMS account(s).

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 processed.

This PAD Agreement may be cancelled at any time provided notice is received, in writing, at the address provided above 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)*
Date *(DD/MM/YYYY)*	Date *(DD/MM/YYYY)*

**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.*

Please remember the following when using Pre-Authorized Debit:

- Payment will be withdrawn on the first of each month.
- Payment for the first month's premium amount must be included with this application.
- You may be subject to an administration charge for each monthly withdrawal.
- Non-Sufficient Funds (NSF) withdrawals will be handled in accordance with GMS' standard NSF policy and in accordance with the rules laid out by The Canadian Payments Association (CPA).
- Information on the administration charge and GMS' standard NSF policy can be found on gms.ca.
- Withdrawal payments will continue until such time as written notice to the contrary is given, in accordance to the right of termination of this PAD Agreement.
- Any change to the information provided under this PAD Agreement or to the product or service for which this PAD Agreement is attached will require that a new PAD Agreement be completed, signed and submitted to GMS Head Office along with a void cheque. We require receipt of this new PAD Agreement at least 10 business days before the next debit is scheduled to be processed.