GMS Group Medical Services

Extended Health/Dental Benefits
Claim Form

Complete all sections and submit to Claims at Group Medical Services 2055 Albert Street PO Box 1949 Regina, SK S4P 0E3

A. Member Information

First Name ______________ Last Name ______________ Date of Birth DD / MM / YYYY Sex: ☐ M ☐ F

Address ______________ City ______________ Province ______ Postal Code ______

Home Phone (   ) ______________ Work Phone (   ) ______________ Email ______________

GMS ID No. ______________ Provincial Health Services No. ______________

Employer *(If applicable)* ______________ Group Plan No. *(If applicable)* ______________

Are any of the claims due to a work-related accident or sickness? ☐ Yes ☐ No

Are any of the claims due to a motor-vehicle accident? ☐ Yes ☐ No

B. Other Coverage Information

Do you, your spouse, or any dependant(s) have coverage under any other insurance plan? ☐ Yes *(Please complete below)* ☐ No *(Please proceed to section C)*

If you have coverage through another insurance plan, you must complete this section.

Name of the Insured and Start Date of Coverage	Insurer	Policy #	Certificate #	Coverage Check all that apply		Who is Covered? Check all that apply
				☐ Health ☐ Drugs ☐ Dental	☐ Vision ☐ Travel	☐ Myself ☐ My Spouse ☐ My Dependants
				☐ Health ☐ Drugs ☐ Dental	☐ Vision ☐ Travel	☐ Myself ☐ My Spouse ☐ My Dependants
				☐ Health ☐ Drugs ☐ Dental	☐ Vision ☐ Travel	☐ Myself ☐ My Spouse ☐ My Dependants
				☐ Health ☐ Drugs ☐ Dental	☐ Vision ☐ Travel	☐ Myself ☐ My Spouse ☐ My Dependants

C. Claims Information (If submitting a dental claim, please attach a Standard Dental Claim Form completed by your dentist's office.)

First Name	GMS ID No.	Date of Birth	Type of Expense (e.g. Ambulance, Crutches, etc.)	No. of Claims	Total Amount of Claims
		DD / MM / YYYY			
		DD / MM / YYYY			
		DD / MM / YYYY			
		DD / MM / YYYY			
		DD / MM / YYYY			
		DD / MM / YYYY			
			Total		

D. Declaration

I/We ("I") declare the statements made herein are true and complete. 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 warrant that neither I nor any person herein listed have any additional coverage through any insurer other than the information listed herein and hereby authorize GMS to coordinate any eligible expenses with any additional insurer listed herein.

I understand that any misrepresentation, incorrect or concealed information or failure to fully complete all sections of this form 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).

X ____ DD / MM / YYYY ____________

Signature of all Claimants 18 years of age and older **Date**

E. Claims Payment Authorization (Optional)

I/We, ____, authorize Group Medical Services to:

- ❑ make this/these claim reimbursements payable to ______________________, who is an adult member of my family's extended health care plan.
- ❑ make this/these and all future claim reimbursements payable to ______________________, who is an adult member of my family's extended health care plan. This authorization shall return in force until GMS is notified, in writing, otherwise.

X ____

Signature of all Claimants 18 years of age and older

Note: If no election is made, payment will be made according to the instructions we have on file. If we have no instructions on file, payment will be made directly to each claimant, if 18 or over, or to the employee if the claimant(s) is/are 17 years of age or under.

Please remember the following when submitting claims:

- All claims must be submitted within twelve (12) months from the date of service.
- Submit only original itemized receipts. Attach all receipts to this claim form.
- GMS does not return receipts; keep a photocopy of the receipt if necessary.
- Include any required physician referrals or orders.
- Please accumulate $20 in total expenses before submitting a claim.
- Submit claims to: **Group Medical Services, Attn: Claims, 2055 Albert Street PO Box 1949 Regina, SK S4P 0E3.**

Group Medical Services respects your privacy. Your personal information is not disclosed to anyone unless written authorization has been provided. Written authorization can be provided by filling out and submitting a Consent to Disclose Personal Information Form; available online at www.gms.ca.