Group Medical Services

Health Benefits Claim Form

Please complete and return this form to *Claims* at *Group Medical Services 2055 Albert Street PO Box 1949 Regina, SK S4P 0E3.*

A. Personal Information

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

Address	City/Town	Province	Postal Code

Phone ( )	Email	GMS ID No.

Provincial Health Services No.	Employer *(if applicable)*	Group Plan No. *(if applicable)*

B. 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 C)*

1	Name of Insured		Start Date of Coverage DD/MM/YYYY	End Date of Coverage *(if applicable)* DD/MM/YYYY
	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 DD/MM/YYYY	End Date of Coverage *(if applicable)* DD/MM/YYYY
	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	

C. Claims Information

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

First Name	GMS ID No.	Date of Birth *(DD/MMYYYY)*	Type of Expense *(i.e. ambulance, crutches, etc.)*	No. of Claims	Total Amount of Claims
			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).

Signature of all Claimants 18 years of age and older	Date *(DD/MMYYYY)*
X	

Please remember the following when submitting claims:

- All claims must be submitted within 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 copy of the receipt if necessary.
- Include any required physician referrals or orders.
- Please accumulate at least $20 in total expenses before submitting a claim.
- Submit to: ***Claims*** at ***Group Medical Services*****, 2055 Albert Street PO Box 1949 Regina, SK S4P 0E3**

Clear Form

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.