# RETIRE ALBERTA MEMBER BENEFITS PLAN
## Enrolment Form

**Please remember to complete the enclosed Pre-Authorized Debit Agreement with your application.**
**Coverage will be effective the first of the month following the date your enrolment form is received and accepted by GMS.**

## A. Personal Information

Do you qualify to be a member of Retire Alberta? *(To qualify you must be a retired first responder or public sector worker from the province of Alberta)*

❑ Yes ❑ No

Where did you retire from?

City/Town: _____ Department/Union: _____

If converting from a spousal or other plan, what is the date coverage ends? *(DD/MM/YYYY)*

***Note:*** *If your application is received more than 60 days after your retirement date, loss of spousal or other coverage, you will be considered a Late Applicant and each individual will be limited to $250 in dental claims for the first 12 months of coverage.*

| First Name | Last Name | Date of Birth *(DD/MM/YYYY)* | ❑ Under 65 ❑ Over 65 | Sex ❑ M ❑ F |
|---|---|---|---|---|
| | | | | |

| Address | City | Province | Postal Code |
|---|---|---|---|
| | | | |

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

## B. Coverage Selection

**Select Your Status** *(select one option)*

| Health & Dental Plan | Single ❑ | Couple ❑ | Family ❑ |
|---|---|---|---|

## 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 dependents 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 enclose a doctor's note or copy of an equivalent document.

## D. Other Coverage Information

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

❑ Yes *(please complete the following)* ❑ No *(please skip to section E)*

| 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)* | Who's covered? *(check all that apply)* |
|---|---|
| ❑ Health ❑ Dental | ❑ 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 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.

I understand that I am purchasing an annual plan from Group Medical Services, and upon cancellation of this plan, will ensure that any unpaid annual premium is remitted in full immediately. I also understand that an annual plan can only be cancelled at renewal.

| Signature of Person Enrolling | Date *(DD/MM/YYYY)* |
|---|---|
| **X** | |

Once this form has been completed in full, please print, scan and email to:
**shannon@retirealberta.com** or **doug@retirealberta.com.** Or mail to:

**Retire Alberta Benefits Plan**
2440 Kensington Rd NW
Calgary, AB T2N 3S1

Questions? **Doug at 1-844-844-5565 ext 1** or **Shannon 1-844-844-5565 ext 2**

**For Office Use Only:** Effective Date of Coverage DD / MM / YYYY

# PRE-AUTHORIZED DEBIT (PAD) Agreement

Please complete this PAD Agreement and return it, along with payment for the first month's premium, 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

| GMS ID No. *(if applicable)* | Group Plan No. *(if applicable)* | Date *(MM/DD/YYYY)* |
|---|---|---|
| | | |

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

☐ Business *(I am an employer paying my employee's premium.)*

| Employer Name | Employee Name |
|---|---|
| | |

☐ Personal *(I am an individual paying my own premium.)*

| 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 or fill out the numbers below.***

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

| Type of Account *(only Canadian accounts are acceptable)* | I request regular monthly payments for the full amount of services delivered to be debited from my account on the | I want to use this same account for claim payments for myself and family members covered under the plan. |
|---|---|---|
| ☐ Savings ☐ Chequing | ☐ 1st or ☐ 15th *(only choose one date)*. | ☐ Yes ☐ No *(If "No", please contact us to set up another 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)* |
| | |

**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 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.