



COVERED INDIVIDUAL'S STATEMENT

1. Name and address of Covered Individual _____
Covered Individual's birthdate (YYYY/MM/DD) _____
2. Patient's Relationship to Covered Individual _____ Patient's birthdate (YYYY/MM/DD) _____
3. Are you or your dependents entitled to benefits under any other plan? No Yes If "Yes," family member insured _____
Name of insuring company _____ Spouse's birthdate (YYYY/MM/DD) _____
4. Are any of the services provided as a result of an accident? No Yes
If "Yes," provide the date and details of the accident. _____
5. Are you claiming for a dependent child who is age 21 or older? No Yes
Child is physically/mentally handicapped (medical evidence may be requested)
 a student enrolled **full time** at (school's name) _____
6. If treatment is a denture, crown or bridge, is it an initial placement? No Yes
If "No," provide the last placement date and reason for replacement. _____
7. Is any treatment required for orthodontic purposes? No Yes
8. Please provide date of accident _____ 20____ at _____ a.m./p.m.
9. Location of accident _____
10. Was the accident work related? No Yes
11. Date of first treatment (YYYY/MM/DD) _____
12. Please provide details of accident _____

All the information I have provided on the form is accurate and complete, to the best of my knowledge, and represents a claim for services rendered to me and/or eligible members of my family. If this claim is being made on behalf of my spouse and/or dependents, I am authorized to disclose information about them for the purposes of assessing and paying a benefit, if any.

I authorize Group Medical Services (GMS), Johnston Group Inc., their agents and service providers to use and exchange information for the purposes of underwriting, administering and adjudicating claims under this benefit plan with any person or organization having relevant information about me, my spouse or dependents. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan. A photocopy of this authorization is as valid as the original.

Signature of Covered Individual _____ Date _____

ALL THE INFORMATION YOU PROVIDE ON THIS FORM WILL BE TREATED AS CONFIDENTIAL.

Once completed, please mail to:
NATIONAL SERVICE CENTRE, 1051 King Edward Street, Winnipeg, MB R3H 0R4
Telephone 1-800-893-7587 • Fax 1-877-526-2515 • info@johnstongroup.ca