F. Method of Payment *(select annual or monthly payment option)*

Please Select One

❑ Annual Payment *(please attach a cheque)* ❑ Monthly Payment *(please complete the following section and attach a cheque for the first month's premium)*

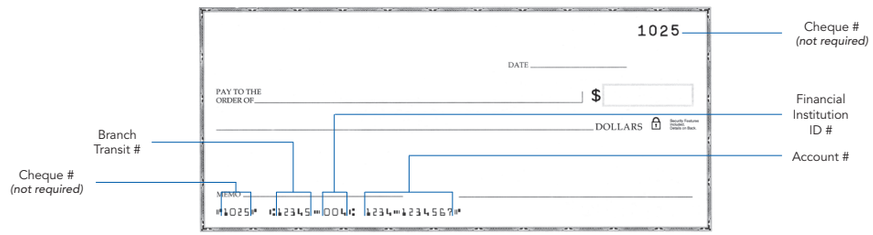
Monthly Pre-Authorized Debit (PAD) *(please list the banking account information for ongoing monthly payments and include a cheque for the first month's premium)*

First Name of Account Holder *(if different than Member)*	Last Name of Account Holder *(if different than Member)*	
Name of Financial Institution	Address	
City	Province	Postal Code

Type of Account *(only Canadian accounts are accepted)*	Monthly Premium Amount	Monthly Withdrawal Date
❑ Savings ❑ Chequing	$	❑ 1st of the month ❑ 15th of the month

Branch Transit Number	Financial Institution ID Number	Account Number

The diagram below shows where you can find the branch transit number, financial institution ID number, and account number on a cheque. You can also attach a void cheque for the account to be debited for monthly payments.



G. Declaration

I/We ("I") declare the statements made herein are true and complete and shall form part of my application for coverage. I hereby authorize any physician, health care provider, other person, hospital or institution to release to Group Medical Services 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.

GMS may, for the purposes of administering any benefits, products or services to be provided pursuant to this policy, for the purposes set out in the GMS privacy statement and for the purposes of determining eligibility for benefits: (a) collect, store and use any personal information about you, which you have provided to GMS, or any personal information which GMS has obtained pursuant to clause (b); and/or (b) obtain personal information about you from, or disclose such personal information to: any Government Plan; the operator of any hospital, clinic, or other health facility; a physician 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 in (a) above.

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 co-ordinate any eligible expenses with any additional insurer that I or any person herein listed may have coverage under.

Member Signature	Date *(DD/MM/YYYY)*
X	

To avoid delays in processing, make sure sections B through G are completed in full. When completed, return to the Plan Administrator.

General Information

- All benefits are per person, per policy year unless otherwise stated.
- Members joining the plan after the Anniversary Date (December 1st) will have their premiums and benefits pro-rated to the Anniversary Date.
- This plan may be paid for on an annual or monthly basis. Coverage must be purchased for one full year.
- In the event that all or any portion of the plan is cancelled by a Member or their Dependant(s) during the year, the remainder of the annual premium becomes due.
- This brochure is an overview of plan coverage. Upon purchase, a detailed policy booklet outlining the benefits will be issued to the Member by GMS.
- GMS reserves the right to amend any benefit provisions, terms and conditions.

Eligibility

To be eligible for coverage, Applicants must be:

- An active Western Canadian Wheat Growers Association Member;
- A Member of an eligible class of members eligible for the plan of group insurance coverage;
- Age seventy-four (74) or under for travel coverage outside of Canada; and
- Insured under a provincial government health insurance plan.

Calculating Monthly or Annual Premium Payments

- Using the Monthly Premium Table, select the WCWG Member province of residence.
- The age of the WCWG Member determines the applicable age band.
- Single Members use the Single premium column, Members with a spouse and/or children use the Family premium column.
- To make monthly payments, add the monthly Health and Dental (if selected) to determine the total monthly premium payment. For Saskatchewan Members, add 6% PST to the total monthly premium as of August 1st, 2017.
- For an annual payment, add the monthly Health and Dental (if selected) to determine the monthly premium amount. Multiply the monthly premium amount by 12 months to determine the total annual premium payment. For Saskatchewan Members, add 6% PST to the total annual premium as of August 1st, 2017.

To Enrol in the Plan

- Detach the enrolment form from this brochure, complete Sections B through G.
- To pay monthly using Pre-Authorized Payments, include a cheque for the first month's premium. To pay annually, include a cheque for the total annual premium.
- Send the completed application with payment to the WCWG Plan Administrator:

Western Canadian Wheat Growers
#74 – 3553 31st Street NW
Calgary, AB T2L 2K7
phone 306.955.0356 fax 403.282.1238
email info@wheatgrowers.ca

Group Medical Services
toll-free 1.800.667.3699 email info@gms.ca www.gms.ca

Effective December 1, 2018 • 0112ABSKMB18
Underwritten by Group Medical Services

Western Canadian Wheat Growers

Health & Dental Benefits Plan

Extended Health Benefits Plan

ACCIDENTAL DENTAL INJURY (100%)
Up to $2,000 per injury per policy year.

AIR AMBULANCE (100%)
Emergency transport within province of residence, maximum of $800 per trip.

AMBULANCE (GROUND) (100%)
Emergency transport within province of residence up to a maximum of $1,500 per policy year.

ARTIFICIAL LIMBS, EYES & LARYNX (100%)
Unlimited payment.

BLOOD PRESSURE MONITORS (100%)
One in the 5 most recent policy years per family.

BREAST PROSTHESIS (100%)
Up to $325 for lateral mastectomy and $650 for a bilateral mastectomy in the 2 most recent policy years.

CASTS AND CRUTCHES (100%)
Unlimited fibreglass casts and rental of crutches.

DIABETIC SUPPLIES & EQUIPMENT
Up to $300 per policy year including one testing device in the three most recent policy years.

HEARING AIDS (100%)
One in the 5 most recent policy years.

HEALTH PRACTITIONERS (100%)
Up to $250 combined per policy year for treatment by a Chiropractor, Massage Therapist, Physiotherapist, Podiatrist and Psychologist.

OSTOMY SUPPLIES & EQUIPMENT (100%)
Up to $300 per policy year.

OXYGEN SUPPLIES & EQUIPMENT (100%)
Up to $500 per policy year for the purchase or rental of oxygen equipment and/or Continuous Positive Airway Pressure supplies (excludes oxygen).

PATIENT WALKERS (100%)
Up to $200 in the 3 most recent policy years.

PREFERRED HOSPITAL ROOMS (100%)
Unlimited private or semi-private rooms.

PRESCRIPTION DRUGS (100%)
Up to $500 per policy year for formulary and non-formulary drugs.

PRIVATE DUTY NURSING (100%)
Up to $2,500 per policy year.

VISION (100%)
Up to $100 in the 2 most recent policy years for eye exams, glasses and/or contact lenses.

WHEELCHAIRS, SCOOTERS & ADJUSTABLE BEDS (100%)
Up to $500 combined maximum in the 5 most recent policy years.

OTHER HEALTH BENEFITS (100%)
Up to a $500 overall maximum per policy year for splints, wigs, knee braces with metal components, mobility aids, embolic stockings, trusses, rib belts, air casts, clavicle straps, cervical collars, shoulder immobilizers, sacroiliac corsets, aero chambers and compressors.

Travel Benefits

Comprehensive emergency medical coverage while travelling – up to a lifetime maximum of $1 million, included with your Extended Health Benefits Plan.

IN CANADA
- up to 180 days per trip

OUT-OF-CANADA
- up to 48 days per trip

Note:
- *Certain exclusions may apply.*
- *Please read the details in the policy booklet before you travel.*

Dental Benefits Plan

Basic & Preventative Dental Services

100% coverage up to a maximum of $1,000 combined per person per policy year. Services include: oral exams, scaling, polishing, fillings, extractions, endodontics and repairs to dental appliances.

Note:
- *Available only when purchased with an Extended Health Benefits Plan.*

WCWG Extended Health & Dental Benefits Plan: Monthly Premium Table*

Region	Coverage	Age	Single	Family
British Columbia & Alberta	Extended Health	18 - 64	$35.29	$79.18
		65 - 74	$57.45	$115.11
		75+	$65.56	$130.97
	Dental	18 - 64	$66.32	$165.79
		65 - 74	$40.38	$80.72
		75+	$40.38	$80.72
Saskatchewan & Manitoba	Extended Health	18 - 64	$27.65	$62.13
		65 - 74	$45.44	$91.16
		75+	$50.44	$100.82
	Dental	18 - 64	$44.38	$110.96
		65 - 74	$28.83	$57.67
		75+	$28.83	$57.67

* This plan may be paid for on an annual or monthly basis. Coverage must be purchased for one full year.

GMS

WESTERN CANADIAN WHEAT GROWERS ASSOCIATION
Health & Dental Benefits Plan Enrolment/Change Form

Please be sure to complete all sections of this form, then return it to the Western Canadian Wheat Growers (WCWG) Plan Administrator.

A. General Information *(to be completed by the Plan Administrator)*

❑ New Member ❑ Termination ❑ Changing Information *If changing information, reason for change:*

Western Canadian Wheat Growers Association Member ID Number	Coverage/Change/Termination Effective Date *(DD/MM/YYYY)*
Signature of Plan Administrator **X**	Date *(DD/MM/YYYY)*

B. Member Information - Initial Application or Changing Information *(to be completed by the Member)*

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

Address	City	Province	Postal Code

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

C. Coverage Selection *(to be completed by the Member)*

Coverage *(please select one)*	Plan Type *(please select one)*
❑ Extended Health Only OR ❑ Extended Health and Dental	❑ Single OR ❑ Family

D. Family Information - Initial Application or Changing Information *(to be completed by the Member)*

	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.

[2] For each dependant age 21 and over:
- in the case of a student dependant under age 25, please complete the over-age dependant questionnaire available at www.gms.ca.
- 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.

E. Other Insurance Coverage *(only include personal or group plans that will continue to be in effect at the same time as the GMS health plan)*

Do any listed Applicants have additional coverage with another insurer? ❑ Yes ❑ No *If "Yes", please complete the section below.*

Insurance Company Name	Name of Insured Person	Policy/Certificate #	Persons Covered under Plan	Coverage *(check all that apply)* ❑ Personal Plan ❑ Group Plan
			❑ Applicant ❑ Spouse ❑ Dependant	❑ Health ❑ Drug ❑ Vision ❑ Dental ❑ Travel
			❑ Applicant ❑ Spouse ❑ Dependant	❑ Health ❑ Drug ❑ Vision ❑ Dental ❑ Travel

Office Use Only: GMS ID# Group # Coverage Effective Date