

ENROLMENT OR CHANGE FORM

Please complete this form to enrol a new plan member for benefits OR to update an existing plan member's information.

Completed forms can be mailed or faxed to:
Green Shield Canada
 P.O. Box 1612, Windsor, ON N5A 7A7
 Fax: 519-739-0688



PLEASE PRINT CLEARLY

SECTION 1 – TO BE COMPLETED BY THE PLAN ADMINISTRATOR											
PLAN SPONSOR INFORMATION	Name of Plan Sponsor			Contract Reference Code		Billing Division		Package/Class			
NOTIFICATION Please check the appropriate box and also be sure to provide the effective date AND the Green Shield Canada (GSC) ID number for existing plan members.	<input type="checkbox"/> New Employee <input type="checkbox"/> Rehire <input type="checkbox"/> Terminate <input type="checkbox"/> Add Dependents <input type="checkbox"/> Terminate Dependents <input type="checkbox"/> Address Change <input type="checkbox"/> Coordination of Benefits (COB) Change <input type="checkbox"/> Other _____					Effective Date ____/____/____ YEAR MONTH DAY			GSC ID Number		
	Does a waiting period apply to this application? (e.g., 3 months) <input type="checkbox"/> No <input type="checkbox"/> Yes _____					Additional Comments					
SECTION 2 – TO BE COMPLETED BY THE PLAN MEMBER											
PLAN MEMBER INFORMATION	Surname			First Name and Middle Initial			Preferred First Name				
	Address					Date of Birth ____/____/____ YEAR MONTH DAY		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female			
	City		Province	Postal Code		Date of Hire ____/____/____ YEAR MONTH DAY		Preferred Language <input type="checkbox"/> English <input type="checkbox"/> French			
	Email Address			Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retiree		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law		Employee Number			
COVERAGE INFORMATION Please be sure to complete your spouse's insurance carrier information, if applicable, for COB purposes.	Coverage with GSC: Please indicate the type of coverage you are applying for with GSC. You may refuse coverage ONLY if you are covered by your spouse's insurance carrier. Health <input type="checkbox"/> Yes <input type="checkbox"/> No Dental <input type="checkbox"/> Yes <input type="checkbox"/> No			Spousal Coverage: Spouse's Insurance Carrier: _____ Plan/Contract Number: _____ Please indicate the type of coverage under your spouse's plan: Health <input type="checkbox"/> Yes <input type="checkbox"/> No Dental <input type="checkbox"/> Yes <input type="checkbox"/> No See COB section below							
COORDINATION OF BENEFITS	<p>If your spouse has other benefit coverage, claims will be paid according to Industry standards: First, your spouse must submit claims to their benefit plan (this is your spouse's primary benefit plan). Next, submit the unpaid portion to your GSC plan (this is your spouse's secondary plan). Your children's claims: First, submit your children's claims to the plan of the parent whose birthday falls earliest in the year regardless of the year of birth. (That's the primary plan.) Next, submit the unpaid portion to the other parent's plan (the secondary plan).</p> <p>In situations of separation or divorce, the following order applies when determining which of the adults are responsible for the coverage of the children: (1) the plan of the parent with custody of the child (2) the plan of the spouse of the parent with custody of the child (3) the plan of the parent not having custody of the child (4) the plan of the spouse of the parent not having custody of the child</p> <p>Please indicate with an "S" below if your child is secondary with GSC.</p>										
DEPENDENT INFORMATION		Surname		First Name		Date of Birth ____/____/____ YEAR MONTH DAY		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Full Time Student	Disabled Dependent	Secondary with GSC "S"
	Spouse					____/____/____ YEAR MONTH DAY		<input type="checkbox"/> Male <input type="checkbox"/> Female			
	Child					____/____/____ YEAR MONTH DAY		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
	Child					____/____/____ YEAR MONTH DAY		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
	Child					____/____/____ YEAR MONTH DAY		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
	Child					____/____/____ YEAR MONTH DAY		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
AUTHORIZATION For further information on our privacy policies and procedures, please refer to our website at greenshield.ca.	By signing this enrolment form or providing my personal information to my employer, I confirm that the information is complete and accurate to the best of my knowledge. I am authorized to release information concerning my spouse and my dependents, for purposes of determining eligibility for benefits and any other services necessary in the administration of my benefits. I certify that I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I agree that GSC may share the personal information with a third party for the administration of benefits for myself and my dependents. I agree that GSC may use my email address, if provided, to correspond with me for benefit purposes. (Note that we do not use email addresses for solicitation purposes.)										
Plan Member's Signature _____			Date _____								
Plan Administrator's Signature _____			Date _____								