

# 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.



PLEASE PRINT CLEARLY

SECTION 1 – TO BE COMPLETED BY THE PLAN ADMINISTRATOR																																																							
<b>PLAN SPONSOR INFORMATION</b>	Name of Plan Sponsor		Contract Reference Code		Billing Division	Package/Class																																																	
<b>NOTIFICATION</b> 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  Date of Hire _____ / _____ / _____ YEAR MONTH DAY  Does a waiting period apply to this application? (e.g., 3 months) <input type="checkbox"/> No <input type="checkbox"/> Yes _____		<b>GSC ID Number</b>  <b>Additional Comments</b>																																																
	SECTION 2 – TO BE COMPLETED BY THE PLAN MEMBER																																																						
<b>PLAN MEMBER INFORMATION</b>	Surname		First Name and Middle Initial		Preferred First Name																																																		
	Address					Gender <input type="checkbox"/> Male <input type="checkbox"/> Female																																																	
	City	Province	Postal Code	Date of Birth _____/_____/_____ 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																																																
<b>COVERAGE INFORMATION</b> Please be sure to complete your spouse's insurance carrier information, if applicable, for COB purposes.	<b>Coverage with GSC:</b> Please indicate the type of coverage you are applying for with GSC. <del>You may refuse coverage ONLY if you are covered by your spouse's insurance carrier.</del>  Health <input type="checkbox"/> Yes <input type="checkbox"/> No Dental <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Spousal Coverage:</b> 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 <b>See COB section below</b>																																																				
<b>COORDINATION OF BENEFITS</b>	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). <b>Your children's claims:</b> 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).  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 (3) the plan of the parent not having custody of the child (2) the plan of the spouse of the parent with custody of the child (4) the plan of the spouse of the parent not having custody of the child  <b>Please indicate with an "S" below if your child is secondary with GSC.</b>																																																						
<b>DEPENDENT INFORMATION</b>	<table border="1"> <thead> <tr> <th></th> <th>Surname</th> <th>First Name</th> <th>Date of Birth</th> <th>Gender</th> <th>Full Time Student</th> <th>Disabled Dependent</th> <th>Secondary with GSC "S"</th> </tr> </thead> <tbody> <tr> <td>Spouse</td> <td></td> <td></td> <td>_____/_____/_____ YEAR MONTH DAY</td> <td><input type="checkbox"/> Male <input type="checkbox"/> Female</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Child</td> <td></td> <td></td> <td>_____/_____/_____ YEAR MONTH DAY</td> <td><input type="checkbox"/> Male <input type="checkbox"/> Female</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> Yes</td> <td></td> </tr> <tr> <td>Child</td> <td></td> <td></td> <td>_____/_____/_____ YEAR MONTH DAY</td> <td><input type="checkbox"/> Male <input type="checkbox"/> Female</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> Yes</td> <td></td> </tr> <tr> <td>Child</td> <td></td> <td></td> <td>_____/_____/_____ YEAR MONTH DAY</td> <td><input type="checkbox"/> Male <input type="checkbox"/> Female</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> Yes</td> <td></td> </tr> <tr> <td>Child</td> <td></td> <td></td> <td>_____/_____/_____ YEAR MONTH DAY</td> <td><input type="checkbox"/> Male <input type="checkbox"/> Female</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> Yes</td> <td></td> </tr> </tbody> </table>								Surname	First Name	Date of Birth	Gender	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	
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<b>AUTHORIZATION</b> 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 _____																																																						

Highlighted sections to be completed. If you do not wish to enroll in benefits please indicate under coverage information.