Green Shield CANADA
Where quality is more than a claim

ENROLLMENT/CHANGE FORM
Please print or type information.
Refer to back of form for important instruction information.

Please fax completed form to your Green Shield Group Administration at 519-255-1316

EMPLOYER (full name):		GREEN SHIELD ID#:	CLIENT CODE	BILLING DIV #

TRANSACTION TYPE:

- ☐ New Subscriber (first day of coverage) — y y y y m m d d
- ☐ Rehire (first day of coverage)
- ☐ Terminate (first day of coverage)
- ☐ Add Dependant (first day of coverage)
- ☐ Terminate Dependant (first day of coverage)
- ☐ Transfer (first day of coverage)
- Other (first day effective) — y y y y m m d d
- ☐ Address
- ☐ New Identification Card
- ☐ Birthdate Correction: Subscriber ☐ Dependant ☐
- ☐ COB Information Change
- ☐ Name Change: Subscriber ☐ Dependant ☐

COMMENTS

SUBSCRIBER INFORMATION

Surname: _____ Legal First Name: _____

Preferred First Name: _____ Init. _____ Birthdate: y y y y m m d d

SIN# ___-___-___ Alternate ID# _____ Gender: Male ☐ Female ☐

Employment Date: y y y y m m d d Coverage: Single ☐ Couple ☐ Family ☐ Language: English ☐ French ☐

Employment Status: Active ☐ Adult Dependant ☐ Retiree ☐ Surviving Spouse ☐ Employment Province: _____

Mailing Address: _____
Street P.O. Box, R.R. #

_____ _____
City Province Postal Code

DEPENDANT INFORMATION

Do dependants have other Green Shield coverage? If yes, please provide GS ID# _____

Co-Ordination of Benefits (COB)
(See reverse for instructions)

Dep.	Surname (if different than Subscriber)	Legal First Name	Preferred First Name	Init	Birthdate (y y y y m m d d)	Gender	DRG	EHS	DEN	VIS	SEMI	OOP
Spouse												
1st Child												
2nd Child												
3rd Child												
4th Child												
5th Child												

COVERAGE INFORMATION

All Coverage Yes ☐ No ☐

Coverage	Family Status (S,C,F)	Effective Date (y y y y m m d d)	Waive Coverage (mark with x)	Coverage	Family Status (S,C,F)	Effective Date (y y y y m m d d)	Waive Coverage (mark with x)
Drug				Semi-Private			
EHS				Audio			
Health (Drug + EHS)				Long Term Care			
Dental				Travel			
Vision							

I hereby apply for Employee Benefit Coverage from Green Shield Canada. I acknowledge all information is complete and accurate. I authorize my employer, policyholder, Green Shield Canada, and their respective representatives and mandataries to give, receive and share any personal information regarding my eligibility and my insurability or those of my dependants, if any, under this plan.

_____ (Signature of Subscriber) _____ (Signature of Employer)

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Please read these special notes carefully since incorrect or incomplete enrollment information could result in denial or improper payment of your claims. Complete each section according to the instructions explained below and sign the bottom of the form when you are sure that the information is complete and accurate. Incomplete forms will be returned.

EMPLOYER SECTION:

(1) Print the full name of your employer, or the name of the group through which you are enrolling for benefits.
(2) Indicate the Green Shield # and Billing Division/Group #. These numbers are used for identification purposes and the absence of these numbers may result in the Enrollment/Change Form not being processed.

Note: If this is for a new Subscriber, the Green Shield # will not yet be assigned and therefore this field can be left blank.

TRANSACTION TYPE SECTION:

This section identifies the type of transaction being processed on this form.
(1) Select the appropriate transaction type.
(2) Indicate the date the transaction is effective.

Note: The date required varies between transaction types so please refer to the note which appears in brackets beside each transaction type.

SUBSCRIBER INFORMATION SECTION:

(1) This section contains all pertinent information relating to the Subscriber.
(2) This form may or may not include a line for Client Defined Fields. If applicable, please include this information which is used for billing purposes.
(3) All fields must be completed (SIN # and Alternate ID # fields are optional).
(4) Please note that for efficient processing of claims, Green Shield requires the legal first name of the Subscriber, along with the preferred first name. This will ensure claims are processed if either of the names are used. For example, if the only name on file is Robert, and a pharmacy submits a claim for Bob, the claim may be denied.
(5) Include the entire mailing address, including postal code.

DEPENDANT INFORMATION SECTION:

This section is used to record the information on all dependants covered under the Subscriber's benefit plan. Please provide the applicable information, beginning with the spouse. The children are then listed in order by birthdate, from the oldest child to the youngest child.

Note: Please provide the legal first name and preferred first name of the dependant. (See #4 in Subscriber Information Section.)

CO-ORDINATION OF BENEFITS SECTION:

COB Categories:

DRG = Drug	*EHS = Extended Health Services*	*DEN = Dental*
VIS = Vision	*SEMI = Semi Private*	*OOP = Out of Province*

If your family members have other benefit coverage, it will be co-ordinated according to industry standards. If this Green Shield coverage is SECONDARY for your spouse and/or children, place an "S" in the applicable box.

Spouse – *Place an "S" if your spouse has other coverage.*

Children – *Place an "S" if the birthday of the "Subscriber" falls later in the year (month and day) than the birth date of the spouse who also provides coverage for the children.*

Separation or Divorce – *Children may qualify as dependents of several adults related to them either naturally or through marriage. 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 in (3) above.

Place an "S" if there is another adult who ranks higher than you based on the list above in the applicable box.

COVERAGE INFORMATION SECTION: (to be completed by Employer)

(1) If the Subscriber is going to be covered under a package of benefits, indicate the name of the Package.
(2) If all coverage is being offered to the Subscriber, tick off yes.
(3) If only certain coverages are being offered, tick no and indicate below which coverages the Subscriber will be receiving, including the family status (single, couple, family) and the effective date (first day of coverage).
(4) If the Subscriber is waiving their right to any of the available coverages, mark the column with an "x" beside the applicable coverage.

SIGNATURE SECTION: