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

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.

- ☐New Employee
- ☐Rehire
- ☐Terminate
- ☐Add Dependents
- ☐Terminate Dependents
- ☐Address Change
- ☐Coordination of Benefits (COB) Change
- ☐Other _____

Effective Date _____ /_____ /_____ (YEAR / MONTH / DAY)

Date of Hire _____ /_____ /_____ (YEAR / MONTH / DAY)

Does a waiting period apply to this application? (e.g., 3 months)

☐No ☐Yes _____

GSC ID Number

Additional Comments

SECTION 2 – TO BE COMPLETED BY THE PLAN MEMBER

PLAN MEMBER INFORMATION

Surname	First Name and Middle Initial	Preferred First Name

Address				Gender
				☐Male ☐Female
City	**Province**	**Postal Code**	**Date of Birth** (YEAR / MONTH / DAY)	**Preferred Language**
				☐English ☐French
Email Address	**Employment Status**	**Marital Status**		**Employee Number**
	☐Active ☐Retiree	☐Single ☐Married ☐Common Law		

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 ☐Yes ☐No
Dental ☐Yes ☐No

Spousal Coverage:
Spouse's Insurance Carrier: _____

Plan/Contract Number: _____

Please indicate the type of coverage under your spouse's plan:

Health ☐Yes ☐No
Dental ☐Yes ☐No
See COB section below

COORDINATION OF BENEFITS

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).

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

Please indicate with an "S" below if your child is secondary with GSC.

DEPENDENT INFORMATION

	Surname	First Name	Date of Birth	Gender	Full Time Student	Disabled Dependent	Secondary with GSC "S"
Spouse			_____ /_____ /_____ (YEAR / MONTH / DAY)	☐Male ☐Female			
Child			_____ /_____ /_____ (YEAR / MONTH / DAY)	☐Male ☐Female	☐Yes	☐Yes	
Child			_____ /_____ /_____ (YEAR / MONTH / DAY)	☐Male ☐Female	☐Yes	☐Yes	
Child			_____ /_____ /_____ (YEAR / MONTH / DAY)	☐Male ☐Female	☐Yes	☐Yes	
Child			_____ /_____ /_____ (YEAR / MONTH / DAY)	☐Male ☐Female	☐Yes	☐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 _____