



### ENROLLMENT / CHANGE FORM

Please print or type information.  
Refer to "INSTRUCTIONS" on reverse  
for important information.

Completed form can be faxed to  
519.739.0688 or mailed to:  
Green Shield Canada, P.O. Box 1612  
Windsor, Ontario N5A 7A7

EMPLOYER (full name)	GREEN SHIELD ID#	CLIENT CODE	BILLING DIVISION #	PACKAGE DESCRIPTION (if applicable)
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**TRANSACTION TYPE**

<input type="checkbox"/> <b>New Subscriber</b> (first day of coverage)	Y Y Y Y	—	M M	—	D D	Other: Y Y Y Y	M M	D D
<input type="checkbox"/> <b>Rehire</b> (first day of coverage)						<input type="checkbox"/> Subscriber Deceased		
<input type="checkbox"/> <b>Terminate</b> (first day of NO coverage)						<input type="checkbox"/> New Identification Card	<input type="checkbox"/> Address	
<input type="checkbox"/> <b>Add Dependent</b> (first day of coverage)						<input type="checkbox"/> Birthdate Correction: Subscriber <input type="checkbox"/>	Dependent <input type="checkbox"/>	
<input type="checkbox"/> <b>Terminate Dependent</b> (first day NO coverage)						<input type="checkbox"/> COB Information Change		
<input type="checkbox"/> <b>Transfer</b> (first day of coverage)						<input type="checkbox"/> Name Change: Subscriber <input type="checkbox"/>	Dependent <input type="checkbox"/>	

**COMMENTS**

**SUBSCRIBER INFORMATION**

Surname: \_\_\_\_\_ Legal First Name: \_\_\_\_\_

Preferred First Name: \_\_\_\_\_ Init. \_\_\_\_\_ Birthdate: Y Y Y Y — M M — D D

Alternate ID # \_\_\_\_\_ Alternate ID # 2 \_\_\_\_\_ Gender: Male  Female

Employment Date: Y Y Y Y — M M — D D Single  Couple  Family  Language: English  French

Employment Status: Active  Adult Dependent  Retiree  Surviving Spouse  **Employment Province:** \_\_\_\_\_

Mailing Address: Street \_\_\_\_\_ P.O. Box, R.R. # \_\_\_\_\_  
City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

**DEPENDENT INFORMATION** Do dependents have other Green Shield coverage? If yes, please provide GS ID # \_\_\_\_\_

**CO-ORDINATION OF BENEFITS (COB)**  
(See INSTRUCTIONS on reverse)

DEP.	Surname (if different than Subscriber)	Legal First Name	Preferred First Name	Init.	Birthdate								GENDER	DRG	EHS	DEN	VIS	SEMI	OOP
					Y	Y	Y	Y	M	M	D	D							
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								Waive Coverage Mark with X	Coverage	Family Status (S,C,F)	Effective Date								Waive Coverage Mark with X
		Y	Y	Y	Y	M	M	D	D				Y	Y	Y	Y	M	M	D	D	
DRUG											SEMI-PRIVATE										
EHS											AUDIO										
HEALTH (Drug & EHS)											LONG TERM CARE										
DENTAL											TRAVEL										
VISION																					

By signing this enrollment form or by providing my personal information to my employer, I agree 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 the purpose of determining eligibility for 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. If my social insurance number is used as my certificate number, I authorize its use for the identification and administration of my group benefits. For further information on our privacy policies and procedures, please refer to your benefit plan booklet and our website at [www.greenshield.ca](http://www.greenshield.ca).

\_\_\_\_\_  
(Signature of Subscriber)

\_\_\_\_\_  
(Signature of Employer)

# INSTRUCTIONS

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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.

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## 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 #, Client Code and Billing Division/Group # and Package Description (if applicable) . 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.*

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## 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.*

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## SUBSCRIBER INFORMATION SECTION:

(1) This section contains all pertinent information relating to the Subscriber.

(2) All fields must be completed (Alternate ID # fields are optional).

(3) 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.

(4) Include the entire mailing address, including postal code.

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## DEPENDENT INFORMATION SECTION:

This section is used to record the information on all dependents 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 dependent. (See #3 in Subscriber Information Section.)*

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## CO-ORDINATION OF BENEFITS SECTION:

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.

**Joint Custody** - If the parents have joint custody and both have the children listed as dependents under their plan, then the claims should be submitted first to the plan of the parent whose birth month and date is earlier in the calendar year.

**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.

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## COVERAGE INFORMATION SECTION: (to be completed by Employer)

(1) If all coverage is being offered to the Subscriber, tick off **YES**.

(2) 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).

(3) If the Subscriber is waiving their right to any of the available coverages, mark the column with an "X" beside the applicable coverage.

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## SIGNATURE SECTION:

This section must be signed by the Subscriber and Employer.