ENROLMENT / CHANGE FORM

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

Completed form must be forwarded to the Human Resources Divisional office

EMPLOYER (full name)	GREEN SHIELD ID#	CLIENT CODE	BILLING DIVISION # leave blank	PACKAGE DESCRIPTION (if applicable)
University of Toronto		U of T		Leave Blank

TRANSACTION TYPE

- ☐ **New Plan Member** (first day of coverage) Y Y Y Y — M M — D D
- ☐ **Rehire** (first day of coverage) Y Y Y Y — M M — D D
- ☐ **Terminate** (first day of **NO** coverage) Y Y Y Y — M M — D D
- ☐ **Add Dependent** (first day of coverage) Y Y Y Y — M M — D D
- ☐ **Terminate Dependent** (first day **NO** coverage) Y Y Y Y — M M — D D
- ☐ **Transfer** (first day of coverage) Y Y Y Y — M M — D D

Other: 1st day effective Y Y Y Y — M M — D D

- ☐ Plan Member Deceased
- ☐ New Identification Card ☐ Address
- ☐ Birthdate Correction: Plan Member ☐ Dependent ☐
- ☐ COB Information Change
- ☐ Name Change: Plan Member ☐ Dependent ☐

COMMENTS

PLAN MEMBER INFORMATION

Surname: _____ Legal First Name: _____

Preferred First Name: _____ Init. _____ Birthdate: Y Y Y Y — M M — D D

Personnel number _____ _____ Gender: Male ☐ Female ☐

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

Employment Status: Active ☐ Overage Dependent ☐ Retiree ☐ Surviving Spouse ☐ **Employment Province:** _____

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

_____ — _____
City Province Postal Code

DEPENDENT INFORMATION

Does your spouse/ dependents have other coverage? please indicate _____

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

DEP.	Surname (if different than Plan Member)	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,F)	Effective Date Y Y Y Y M M D D	Waive Coverage Mark with X	Coverage	Family Status (S,F)	Effective Date Y Y Y Y M M D D	Waive Coverage Mark with X
DRUG				SEMI-PRIVATE			
EHS							
DENTAL							
VISION							

By signing this enrolment 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.

Date:( ) _____ (Signature of Plan Member) Date: ( ) _____ (Signature of Employer)

INSTRUCTIONS

Please read these special notes carefully since incorrect or incomplete enrolment 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 #, 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 Enrolment/Change Form not being processed.

Note: *If this is for a new Plan Member, 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.*

PLAN MEMBER INFORMATION SECTION:

(1) This section contains all pertinent information relating to the Plan Member.
(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 Plan Member, 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.

DEPENDENT INFORMATION SECTION:

This section is used to record the information on all dependents covered under the Plan Member'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 Plan Member Information Section.)*

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 "Plan Member" 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.

COVERAGE INFORMATION SECTION: (to be completed by Employer)

(1) If all coverage is being offered to the Plan Member, tick off **YES**.
(2) If only certain coverages are being offered, tick **NO** and indicate below which coverages the Plan Member will be receiving, including the family status (single, couple, family) and the effective date (first day of coverage).
(3) If the Plan Member is waiving their right to any of the available coverages, mark the column with an "X" beside the applicable coverage.

SIGNATURE SECTION:

This section must be signed by the Plan Member and Employer.