## **ENROLMENT / CHANGE FORM**

Please print or type information.

Completed form can be forwarded to USMC Payroll Department

	green s		r leade print or type information.											81 St. Mary Street or faxed at 416-926-7120														
EMPLOYER (full name)									GREEN SHIELD ID# COI					CONT	RACT		BILLING DIVISION #						PACKAGE DESCRIPTION					
, ,								GREEN SHIELD ID#					REFERENCE CODE							i <b>ν</b> π	(if applicable)							
St. Michael's College - CUPE HCSA Plan TRANSACTION TYPE								UOF1									24394											
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Rehire (first day of coverage)						<del></del>								Plan Member Deceased														
Terminate (first day of NO coverage)  Add Dependent (first day of coverage)							├-  <sup>-</sup>								New Identification Card													
Add Dependent (first day of coverage)  Terminate Dependent (first day NO coverage)							<del></del>													II WEII	ibei		Depei	ident				
Transfer (first day of coverage)									_									COB Information Change  Name Change: Plan Member Dependent										
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