



ENROLMENT / CHANGE FORM

Please print or type information.

Completed form can be forwarded to USMC Payroll Department 81 St. Mary Street or faxed at 416-926-7120

EMPLOYER (full name) St. Michael's College - CUPE HCSA Plan	GREEN SHIELD ID#	CONTRACT REFERENCE CODE UOFT	BILLING DIVISION # 24394	PACKAGE DESCRIPTION (if applicable)
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TRANSACTION TYPE

<input type="checkbox"/> New Plan Member (first day of coverage)	Y Y Y Y	-	M M	-	D D	1st day effective	Y Y Y Y	-	M M	-	D D
<input type="checkbox"/> Rehire (first day of coverage)											
<input type="checkbox"/> Terminate (first day of NO coverage)											
<input type="checkbox"/> Add Dependent (first day of coverage)											
<input type="checkbox"/> Terminate Dependent (first day NO coverage)											
<input type="checkbox"/> Transfer (first day of coverage)											

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

COMMENTS

PLAN MEMBER INFORMATION

Surname: _____ Legal First Name: _____
 Y Y Y Y M M D D

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

Alternate ID # _____ Alternate ID # 2 _____ Gender: Male Female

Employment Date: _____ 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 _____

Email Address: _____

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 Plan Member)	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																			

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.

 (Signature of Plan Member)

 (Signature of Employer)