Green Shield CANADA
*Where quality is more than a claim*

**ENROLLMENT / CHANGE FORM**
Please print or type information.
Refer to back of form for important instruction information.

Please return completed form to U of T
215 Huron Street, 8th Floor
Toronto, Ontario, M5S 1A2

| U OF T: Professional/Managers 6 - 9 | EMPLOYEE ID #: | CLIENT CODE | BILLING DIV |
|---|---|---|---|
| | | UOFT | 31134 |

**TRANSACTION TYPE:**

- ☐ **New Subscriber** (first day of coverage) y y y y — m m — d d
- ☐ **Rehire** (first day of coverage)
- ☐ **Terminate** (first day of **no** coverage)
- ☐ **Add Dependant** (first day of coverage)
- ☐ **Terminate Dependant** (first day of **no** coverage)
- ☐ **Transfer** (first day of coverage)

Other (first day effective) y y y y — m m — d d

- ☐ Address
- ☐ New Identification Card
- ☐ Birthdate Correction: Subscriber ☐ Dependant ☐
- ☐ Overage Dependant
- ☐ Name Change: Subscriber ☐ Dependant ☐

**COMMENTS**

**SUBSCRIBER INFORMATION**

**Surname:** _____ **Legal First Name:** _____

**Birthdate:** y y y y — m m — d d **Gender:** Male ☐ Female ☐ **Employee ID#** _____

**Employment Date:** y y y y — m m — d d **Coverage:** Single ☐ Family ☐ **Employment Province:** _____

**Employment Status:** Active ☐ Retiree ☐ Surviving Spouse/Partner ☐ **Language:** English ☐ French ☐

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

_____
City Province Country Postal Code

**DEPENDANT INFORMATION**

**Does your spouse/dependant have other coverage? If yes, please indicate:** _____

**Co-Ordination of Benefits (COB)**

| Dependant Change Add | Dependant Change Delete | Dep. | Surname (if different than Subscriber) | Legal First Name | Birthdate y y y y m m d d | Gender | EHS | DEN | VIS | SEMI |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Spouse/ Partner | | | | | | | | |
| | | 1st Child | | | | | | | | |
| | | 2nd Child | | | | | | | | |
| | | 3rd Child | | | | | | | | |
| | | 4th Child | | | | | | | | |
| | | 5th Child | | | | | | | | |

I hereby apply for Employee Benefit Coverage from Green Shield Canada. I acknowledge all information is complete and accurate. I authorize my employer, the policyholder, Green Shield Canada, and their respective representatives and mandataries to give, receive and share any personal information regarding my eligibility and my insurability or those of my dependants, if any, under this plan.

_____ (Signature of Staff Member) _____ (Signature of Benefits Administrator)

_____ (Date Completed) Herald Press Limited 81041 UofT _____ (Date Signed) (Over)