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 the Bursar's Office

EMPLOYER (full name): Victoria University CUPE 3902 Unit 2	EMPLOYEE ID #:	CLIENT CODE	BILLING DIV #
		U OF T	30600

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)