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

TRANSACTION TYPE

- ☐ **New Plan Member** (first day of coverage)
- ☐ **Rehire** (first day of coverage)
- ☐ **Terminate** (first day of **NO** coverage)
- ☐ **Add Dependent** (first day of coverage)
- ☐ **Terminate Dependent** (first day **NO** coverage)
- ☐ **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

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

Employment Date: Y Y Y Y — M M — D D 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 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												

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)