Green Shield CANADA

PLEASE INDICATE ON MAILING ENVELOPE
Attn: Drug Dept., P.O. Box 1652, Windsor, ON N9A 7G5
Attn: EHS Dept., P.O. Box 1699, Windsor, ON N9A 7G6
Attn: Out of Country Dept. P.O. Box 1606, Windsor, ON N9A 6W1
Attn: Vision, Accommodation, P.O. Box 1615, Windsor, ON N9A 7J3

FOR CLAIMS REQUIRING FORM COMPLETION, REQUEST FORMS FROM CUSTOMER SERVICE:
CUSTOMER SERVICE CENTRE
1 888 711-1119

CLAIM SUBMISSION FORM

Mandatory Declaration

Do you have any other group insurance coverage that may include the claim as a benefit?

Yes ☐ No ☐

If yes, please indicate name of other insuring agency:

_____

If other coverage is Green Shield, indicate Green Shield Identification No.: _____

Submit copies of Other Carrier's Statement along with copies of corresponding receipts.

Are any of the enclosed claims due to

1. A work related injury Yes ☐ No ☐
2. A motor Vehicle Accident Yes ☐ No ☐

PLEASE INCLUDE PAID RECEIPTS

Subscriber Surname including Alternate surname if applicable _____

Group Number OR Company Name _____ _____

Green Shield Identification Number _____ - ☐☐

Only include names of patients with receipts attached. - ☐☐ - ☐☐ - ☐☐

Patient's First Name _____ _____ _____ _____

Birth Date **Year** ☐☐ **Month** ☐☐ ☐☐ ☐☐ ☐☐

Street Address _____

City _____ **Province** _____ **Country** _____

Postal Code ☐☐☐ ☐☐☐ **Telephone** ☐☐☐-☐☐☐-☐☐☐☐

_____

Subscriber signature