Green Shield CANADA

the co-operators

ENROLLMENT or CHANGE FORM

Complete this form to enroll for Employee Benefits or to change status of existing information. Refer to the back of this form for important instructions to accurately complete each section.

PLEASE PRINT CLEARLY

"A" EMPLOYEE INFORMATION

Employer Name:	Gender: Female ❑ Male ❑	Badge/Employee No.:	Earnings:
Employee Last Name:	Language: English : ❑ French: ❑	Green Shield Subscriber No.:	❒ Hourly ❒ Weekly ❒ Bi-Weekly ❒ Monthly ❒ Annually ❒ Semi-Annually
First Name & Initial:		Green Shield Group No.:	
Home Mailing Address:		Class No./Classification:	
City:		Alternate ID #:	No. of Hours Per Week Worked:
Province:	Postal Code:	Family Coverage No. of Dependents:	Occupation:
Date of Birth (Year/Month/Day):			Date of Hire: ____ Year/Month/Day

Coverage for: Single ❒ Couple ❒ Family ❒ Waived ❒

Single ❒ Married ❒ Common Law ❒ Widowed ❒ Separated ❒ Divorced ❒

Beneficiary's Last Name **First Name** **Relationship**

Revocable * ❒

Irrevocable ❒

***Beneficiary is revocable unless otherwise stated on this enrollment form.**

"B" NOTIFICATION

❒ New Employee

❒ Rehire

❒ Terminated Employee

Year / Month / Day (Last Date of Coverage)

❒ Add Dependents

❒ Delete Dependents

❒ COB Changes

❒ Other

Coverage Effective Date:

____

Year / Month / Day

Special Notes: Office Use Only

Witness Signature: (Designated Beneficiary cannot serve as witness) **Date:**

By signing this enrollment form or by providing my personal information to my employer, I agree that the information is complete and accurate, to the best of my knowledge. I authorize my employer, group plan administrator, and Co-operators Life Insurance Company or its agents, to release and exchange information regarding me, my spouse, and my dependants for the purposes of determining eligibility for benefits and administration of the group benefits plan. If my social Insurance number (SIN) is used as my certificate number, I authorize its use for the identification and administration of my group benefits, and understand that the provision of my SIN for such purposes is optional and not a condition of service. For further information on our privacy policies and procedures, please refer to your benefit plan booklet and our website at www.greenshield.ca.

I hereby apply for Employee Benefit Coverage from the Co-operators Life Insurance Company and Green Shield Canada for which I am or may become eligible and I authorize the deduction from my pay contributions if any, to be made by me. I the undersigned hereby certify that I have been living with ______________________ since ____/_____/_____ and representing him/her as my spouse or my (common law) spouse. I further certify that I and/or my (common law) spouse are solely responsible financially for either of our children claimed for insurance purposes. I acknowledge all information is complete and accurate.

Date: Signature of Employee:

Coverage Applied for with: the co-operators

❒ Basic Life ❒ Basic AD&D ❒ Dependent Life

❒ Weekly Indemnity ❒ Long Term Disability ❒ Optional Life

Green Shield

❒ Health

❒ Dental

"C" CO-ORDINATION OF BENEFITS						"D" DEPENDENT ENROLLMENT INFORMATION				
Drug	EHS	Dent	Vis	Hosp	OOP	Dependents	Last Name	First Name	Date of Birth Year/Month/Day	Sex
						Spouse				
						1st Child				
						2nd Child				
						3rd Child				
						4th Child				
						5th Child				

"E" Mark X To Waive	Office Use Only: Plan	Effect. Date
Drug		
EHS		
Dental		
Vision		
Hospital		
Audio		
Prosth		
Nursing		
OOP		

Signed by:

Name of Employer ____________________

Please read these special notes carefully since incorrect or incomplete enrollment information could result in denial or improper payment of your claims. Complete each section according to the instructions explained below and sign the bottom of the form when you are sure that the information is complete and accurate. Incomplete forms will be returned.

SECTION "A" EMPLOYEE INFORMATION

1) Print your name and full mailing address in the designated areas. Please record the first name by which you will refer to yourself when submitting claims. (ie. If you will use Robert on your claims, don't use Bob when completing this form).
2) Enter birth year, then mark with an "x" to indicate sex (male or female) and family status (single, couple, family).
3) Designate a beneficiary. Please ensure that you have indicated your beneficiary's relationship to you. Please ensure it is also witnessed and dated by someone other than the beneficiary.
4) If you are in common-law relationship, please complete the common-law declaration.

SECTION "A" EMPLOYER INFORMATION

1) Please record employee's salary and payment period.
2) Please record average number of hours worked.
3) Please record the employee's occupation and department.
4) Please record the date when fulltime or part-time employment commenced.
5) If your Plan benefits are different for classes of employees (i.e. union/non union; management/staff), please indicate classification the employee falls into.
6) Please sign (plan administrator, manager) and record employer's name at the bottom of the page.

SECTION "B" NOTIFICATION

1) Mark with an "x" to indicate one or more of the Notification types shown along with the effective date.

SECTION "C" CO-ORDINATION OF BENEFITS

If your family members have other benefit coverage they will be co-ordinated according to industry standards. If this Green Shield coverage is **SECONDARY** for your spouse and/or children, you must place an "S" in the applicable box.

SPOUSE

Place an "S" if your spouse has other coverage.

CHILDREN

Place an "S" if the birth date of the "Employee falls later in the year (month and day) than the birth date of your spouse who also provides coverage for the children.

SEPARATION or DIVORCE

Children may qualify as dependents of several adults related to them either naturally or through marriage. In situations of separation or divorce, the following order applies when determining which of the adults are responsible for the coverage of the children:

1) the plan of the parent with custody of the child
2) the plan of the spouse of the parent with custody of the child
3) the plan of the parent not having custody of the child
4) the plan of the spouse of the parent in 3) above.

Place an "S" if there is another adult who ranks higher than you based on the list above.

SECTION "D" DEPENDENT ENROLLMENT INFORMATION

1) Print the surname and full name of each person eligible to be covered under your employer's benefit policies. Be sure to use the first name which will be used when submitting claims (ie. If Betty will be used when submitting claims, don't use Elizabeth when completing this form).
2) Enter "M" (male) or "F" (female) to identify the sex of each dependent.
3) Enter the full birth for each dependent. Please confirm the accuracy of these birth dates, since they will affect claims payment and dependent eligibility.

SECTION "E" TO WAIVE COVERAGE

1) If you are eligible for coverage through your spouse's plan and so choose to waive coverage for any plan type, enter "x" in the appropriate plan box for :

   Drug, EHS (Extended Health Services), Dental, Vision (eyeglasses) Semi (semi-private accommodation), Audio (hearing aids), Prosth (prosthetic equipment), Nursing (nursing home accommodation), OOP (out-of-province).