

EMPLOYER (full name): UOFT CUPE 3902 UNIT 3 (HCSA)	EMPLOYEE ID #:	CLIENT CODE U OF T	BILLING DIV # 30531
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TRANSACTION TYPE:

<input type="checkbox"/> New Subscriber (first day of coverage) y y y y m m d d <input type="checkbox"/> Rehire (first day of coverage) - - <input type="checkbox"/> Terminate (first day of no coverage) - - <input type="checkbox"/> Add Dependant (first day of coverage) - - <input type="checkbox"/> Terminate Dependant (first day of no coverage) - - <input type="checkbox"/> Transfer (first day of coverage) - - 	<input type="checkbox"/> Other (first day effective) y y y y m m d d <input type="checkbox"/> Address <input type="checkbox"/> New Identification Card <input type="checkbox"/> Birthdate Correction: Subscriber <input type="checkbox"/> Dependant <input type="checkbox"/> <input type="checkbox"/> Overage Dependant <input type="checkbox"/> Name Change: Subscriber <input type="checkbox"/> Dependant <input type="checkbox"/>
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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 <small>Add Delete</small>	Dep.	Surname <small>(if different than Subscriber)</small>	Legal First Name	Birthdate						Gender	EHS	DEN	VIS	SEMI
				y	y	y	y	m	m					
	Spouse/ Partner													
	1 st Child													
	2 nd Child													
	3 rd Child													
	4 th Child													
	5 th 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)