

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										"B" NOTIFICATION				
Employer Name:			Gender: Female <input type="checkbox"/> Male <input type="checkbox"/>		Badge/Employee No.:			Earnings:		<input type="checkbox"/> New Employee <input type="checkbox"/> Rehire <input type="checkbox"/> Terminated Employee				
Employee Last Name:			Language: English : <input type="checkbox"/> French: <input type="checkbox"/>		Green Shield Subscriber No.:			<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually						
First Name & Initial:				Green Shield Group No.:						Year / Month / Day (Last Date of Coverage)				
Home Mailing Address:				Class No./Classification:										
City:				Alternate ID #:			No. of Hours Per Week Worked:			<input type="checkbox"/> Add Dependents <input type="checkbox"/> Delete Dependents <input type="checkbox"/> COB Changes <input type="checkbox"/> Other Coverage Effective Date:				
Province:		Postal Code:		Family Coverage No. of Dependents:			Occupation:							
Date of Birth (Year/Month/Day):				Date of Hire:			Year/Month/Day							
Coverage for:										Year / Month / Day				
Single <input type="checkbox"/> Couple <input type="checkbox"/> Family <input type="checkbox"/> Waived <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law* <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/>														
Beneficiary's Last Name			First Name			Relationship			Revocable * <input type="checkbox"/>					
									Irrevocable <input type="checkbox"/>					
*Beneficiary is revocable unless otherwise stated on this enrollment form. If designated beneficiary is a minor, consider naming a trustee. Relationship to employee:														
I hereby apply for coverage for which I am, or may become eligible under the Group Insurance Plan issued by Wawanesa Life and Green Shield Canada. I consent to Wawanesa Life and Green Shield Canada collecting, using and disclosing my personal information for the purposes of: establishing and maintaining communications with me; underwriting risks on a prudent basis; investigating and paying claims; detecting and preventing fraud; offering and providing products and services to meet my needs; compiling statistics and acting as required or authorized by law. I recognize that in providing service to me in the future and providing me with the benefits included in the Group Benefits Plan I am enrolling in, Wawanesa Life and Green Shield Canada may need to collect, use and disclose additional personal information about me. I confirm that this consent applies to that personal information as well. I acknowledge that I only enroll, at this time or any future time, dependents who have authorized me to provide their information and consent to the collection, use and disclosure of that information for the purposes listed above. I authorize Wawanesa Life and Green Shield Canada, any healthcare provider, my plan administrator, other insurance companies, or benefit providers working with Wawanesa Life and Green Shield Canada to exchange information, when necessary to determine my eligibility for coverage and to administer the Group Insurance Plan. I authorize the deduction from my pay for any contributions required under the Group Insurance Plan, if required. *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: _____ Date: _____ Witness Signature: (Designated Beneficiary cannot serve as witness) _____														
Coverage Applied for with: Wawanesa Life						Green Shield								
<input type="checkbox"/> Basic Life <input type="checkbox"/> Basic AD&D <input type="checkbox"/> Dependent Life <input type="checkbox"/> Weekly Indemnity <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Optional Life						<input type="checkbox"/> Health <input type="checkbox"/> Dental								
"C" CO-ORDINATION OF BENEFITS						"D" DEPENDENT ENROLLMENT INFORMATION					"E" Mark X To Waive		Office Use Only	
Drug	EHS	Dent	Vis	Hosp	OOP	Dependents	Last Name	First Name	Date of Birth Year/Month/Day	Sex	Drug	Plan	Effect. Date	
						Spouse					EHS			
						1 st Child					Dental			
						2 nd Child					Vision			
						3 rd Child					Hospital			
						4 th Child					Audio			
						5 th Child					Prosth			
Signed by: Authorized Plan Administrator _____ Print Name _____											Nursing			
											OOP			

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).