

<b>EMPLOYER (full name):</b> Victoria University CUPE 3902 Unit 2	<b>EMPLOYEE ID #:</b>	<b>CLIENT CODE</b> U OF T	<b>BILLING DIV #</b> 30600
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**TRANSACTION TYPE:**

<input type="checkbox"/> <b>New Subscriber</b> (first day of coverage) <span style="float:right">y y y y m m d d</span> <input type="checkbox"/> <b>Rehire</b> (first day of coverage) <span style="float:right">        -       -      </span> <input type="checkbox"/> <b>Terminate</b> (first day of <b>no</b> coverage) <span style="float:right">        -       -      </span> <input type="checkbox"/> <b>Add Dependant</b> (first day of coverage) <span style="float:right">        -       -      </span> <input type="checkbox"/> <b>Terminate Dependant</b> (first day of <b>no</b> coverage) <span style="float:right">        -       -      </span> <input type="checkbox"/> <b>Transfer</b> (first day of coverage) <span style="float:right">        -       -      </span>	<input type="checkbox"/> <b>Other</b> (first day effective) <span style="float:right">y y y y m m d d</span> <input type="checkbox"/> <b>Address</b> <input type="checkbox"/> <b>New Identification Card</b> <input type="checkbox"/> <b>Birthdate Correction:</b> Subscriber <input type="checkbox"/> Dependant <input type="checkbox"/> <input type="checkbox"/> <b>Overage Dependant</b> <input type="checkbox"/> <b>Name Change:</b> Subscriber <input type="checkbox"/> Dependant <input type="checkbox"/>
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**COMMENTS**

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**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:** \_\_\_\_\_

Dependant Change <small>Add Delete</small>		Dep.	Surname <small>(if different than Subscriber)</small>	Legal First Name	Co-Ordination of Benefits (COB)												
					Birthdate					Gender	EHS	DEN	VIS	SEMI			
					y	y	y	y	m	m	d	d					
		Spouse/ Partner															
		1 <sup>st</sup> Child															
		2 <sup>nd</sup> Child															
		3 <sup>rd</sup> Child															
		4 <sup>th</sup> Child															
		5 <sup>th</sup> 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)