GreenShield™

JOINT BENEFITS ENROLMENT OR CHANGE FORM

the co-operators®

Please complete this form to enrol a new plan member for benefits OR to update an existing plan member's information.

SECTION 1 – TO BE COMPLETED BY THE PLAN ADMINISTRATOR

PLAN SPONSOR INFORMATION

Plan Sponsor Name	Contract Ref. Code	CLIC Policy #	Billing Division	Package	Class

NOTIFICATION
Please check the appropriate box and be sure to provide the effective date. For existing plan members, include the Green Shield Canada (GSC) ID # or Employee #/Alt ID # if applicable.

- ☐ New Employee
- ☐ Rehire/reinstatement
- ☐ Terminate[1]
- ☐ Add Dependents
- ☐ Terminate Dependents[1]
- ☐ Address Change
- ☐ Salary Change
- ☐ Coordination of Benefits (COB) Change
- ☐ Other _____

Effective Date _____/_____/_____ (YEAR / MONTH / DAY)

[1]*For terminations, effective date is first day without coverage*

Does a waiting period apply to this application? (e.g. 3 months)
☐ No ☐ Yes _____

GSC ID #

Employee #/Alt ID #

Employment Province

Date of Hire[2]
_____/_____/_____ (YEAR / MONTH / DAY)

[2]*If plan member's employment status changed from part-time to full-time resulting in benefit eligibility, indicate date of full-time status in "date of hire" field to the left.*

Employment Status
☐ Part-time ☐ Full-time ☐ Retiree

Salary
$
☐ Hourly ☐ Annually ☐ Monthly ☐ Bi-Monthly ☐ Weekly ☐ Bi-Weekly

# of Hours/Week

Occupation

SECTION 2 – TO BE COMPLETED BY THE PLAN MEMBER

PLAN MEMBER INFORMATION

Surname	First Name and Middle Initial	Preferred First Name (if different)

Address	City	Province	Postal Code

Cellphone	Date of Birth	Sex	Preferred Language
	_____/_____/_____ (YEAR / MONTH / DAY)	☐ Male ☐ Female ☐ Non-binary	☐ English ☐ French

Email Address

Marital Status
- ☐ Single
- ☐ Married
- ☐ Common Law[3]

[3]If common law, please provide the date you started living together:
_____/_____/_____ (YEAR / MONTH / DAY)

COVERAGE INFORMATION
Please be sure to complete your spouse's insurance carrier information, if applicable, for Coordination of Benefits purposes.

Coverage with GSC:
Please indicate the type of coverage you are applying for with GSC. You may refuse coverage ONLY if you are covered by your spouse's insurance carrier.

Health ☐ Yes ☐ No
Dental ☐ Yes ☐ No

Provincial Coverage:
Do you and all of your dependents indicated below have valid Provincial Health Plan coverage?
☐ Yes ☐ No

Spousal Coverage:
Spouse's Insurance Carrier: _____
Plan/Contract Number: _____
Please indicate the type of coverage under your spouse's plan:
Health ☐ Yes ☐ No **Dental** ☐ Yes ☐ No
See Coordination of Benefits section below

COORDINATION OF BENEFITS

If your spouse has other benefit coverage, claims will be paid according to industry standards: First, your spouse must submit claims to their benefit plan (this is your spouse's primary benefit plan). Next, submit the unpaid portion to your GSC plan (this is your spouse's secondary plan).
Your children's claims: First, submit your children's claims to the plan of the parent whose birthday falls earliest in the year regardless of the year of birth. (That's the primary plan.) Next, submit the unpaid portion to the other parent's plan (the secondary plan).
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 not having custody of the child

Please indicate with an "S" below if your spouse or child is secondary with GSC.

DEPENDENT INFORMATION
Completion of dependent information is mandatory if the plan member has dependent life coverage.

	Surname	First Name	Date of Birth	Sex	Full-Time Student	Depend. with Special Needs	GSC Plan is Secondary "S"	Dep. Life Only
Spouse			_____/_____/_____ (YEAR / MONTH / DAY)	☐ Male ☐ Female ☐ Non-binary				☐ Yes
Child			_____/_____/_____ (YEAR / MONTH / DAY)	☐ Male ☐ Female ☐ Non-binary	☐ Yes	☐ Yes		☐ Yes
Child			_____/_____/_____ (YEAR / MONTH / DAY)	☐ Male ☐ Female ☐ Non-binary	☐ Yes	☐ Yes		☐ Yes

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SECTION 3 – TO BE COMPLETED BY THE PLAN MEMBER

BENEFICIARY INFORMATION

Corrections to beneficiaries must be initialed. Original forms will be requested in the event of a Life claim.

You may wish to designate a contingent beneficiary(ies) to receive any proceeds if all the primary beneficiary(ies) predecease you.

In Quebec, the designation of your spouse/common law as a beneficiary is irrevocable unless you declare otherwise.

Primary Beneficiary Surname	First Name	Relationship to Employee	Date of Birth (YYYY/MM/DD)	% Share (Must Equal 100%)

☐ **Revocable** ☐ **Irrevocable** (If irrevocable is chosen, you may not change the beneficiary without written consent from the beneficiary.)

Contingent Beneficiary Surname	First Name	Relationship to Employee	Date of Birth (YYYY/MM/DD)	% Share (Must Equal 100%)

TRUSTEE

If beneficiary is a minor, a trustee must be named. In Quebec, appointment of a trustee is not an available option.

Trustee Surname	Trustee First Name	Relationship to Employee	Date of Birth (YYYY/MM/DD)

SECTION 4 – PRIVACY AND AUTHORIZATION

PRIVACY CONSENT

For further information on our privacy policies and procedures, please refer to our website at www.greenshield.ca

At Green Shield Canada ("**GSC**," "**we**," "**us**" or "**our**"), respecting and protecting the privacy and confidentiality of your personal information is a priority. In order to provide you with the services for which we have been engaged, we need you to understand, and consent to, a few things. We may collect/receive from you or other parties and use, share, disclose and process your personal information and, if applicable, that of your spouse, children and other dependents (collectively, "**you**" or "**your**"), which may include name, age, claims history, income, email address, service providers that may have been used and banking information. We may do this for various purposes related to the administration of your benefits plan and to provide you other products and services, including but not limited to: benefits coordination with other carriers; administration and adjudication of claims; auditing, investigating, and taking steps connected to the prevention or suppression of suspected or proven improper or fraudulent claims; identity checks; billing and collection of premiums; medical underwriting; communication with other service providers, communication with third parties to confirm the accuracy of claims, provide contracted services, or for health management purposes or programs; collecting information about services that are provided, analyzing data, including information on how you use our products and services, to help us make informed decisions and improve the products and services we offer; determining if there are other products and services that you might be interested in, and sending you details about them; compliance with applicable laws and regulations; and such other activities that a reasonable person would consider associated with the administration of your benefit plan. In carrying-out these purposes, we may collect, receive, share or disclose your personal information with others outside of GSC, including, but not limited to: your employer, sponsor(s) of your benefit plan, and insurance advisors, if your benefits are provided through your employer's group benefits plan; benefits providers (e.g. pharmacists, massage therapists); professional regulatory bodies (e.g. College of Pharmacists); government agencies; applicable law enforcement bodies (local, provincial and federal); industry drug pooling entities (e.g. Canadian Drug Insurance Pooling Corporation); GSC's third party service providers who assist us in administering your benefits plan and providing you with other related products and services and such other third parties as may be appropriate or reasonably necessary in carrying out the purposes set out above. Although sharing of personal information is inherently risky, we implement commercially-acceptable procedures to secure and protect your personal information using appropriate technological, physical and organizational measures designed to protect personal information. In the event of an unauthorized release by us of your personal information, we will notify you in accordance with applicable privacy laws. More information about our privacy practices is available in our Privacy Policy at www.greenshield.ca, which is a necessary and integral part of this privacy consent. We may from time to time revise our Privacy Policy to reflect changes in, for example, legislation or regulation, or as we introduce new features, products or services. The most current version of the policy will govern how we process your personal data and will always be available on www.greenshield.ca. You can contact our Privacy Officer at privacy.office@greenshield.ca if you have a question or complaint.

AUTHORIZATION AND DECLARATIONS

By signing below, you are providing your consent to GSC's collection, use and disclosure of your personal information as explained above, and you are acknowledging that you are authorized by your spouse, children and other dependents (if applicable) to disclose and receive their personal information, and to provide this privacy consent on their behalf. You agree that a photocopy, facsimile or electronic version of this consent will be as valid as the original. You can withdraw your consent at any time by providing notice in writing to GSC at privacy.office@greenshield.ca, but, if you do so, GSC will no longer be able to administer your benefits plan and process your claims.

Plan Member's Signature _____ Date _____

Plan Administrator's Signature _____ Date _____

SECTION 5 – MAILING INSTRUCTIONS

Email copy of completed signed form to: jointadmin@greenshield.ca

or mail to: Green Shield Canada, Attn: Joint Administration, PO Box 1612, Windsor, ON N5A 7A7

IBEW Local Union 773 Pension Plan

Registration #0349464

APPOINTMENT OR CHANGE OF BENEFICIARY

Instructions

- If you have a spouse, he or she is automatically your only pension beneficiary by law unless you and your spouse have signed a spouse's waiver.
- If you don't have a spouse, you may name anyone you want as your beneficiary(ies). If you name more than one beneficiary, death benefits will be divided in equal shares among them unless you indicate otherwise. If you don't have a spouse and you don't name a beneficiary, pension death benefits will be paid to your estate unless otherwise indicated in your will.
- Your Contingent Beneficiary will apply only if no Beneficiary named is alive to receive your death benefits.
- Be sure to complete this form in full and have someone other than your beneficiary(ies) witness it

EMPLOYEE

Last Name	First Name	
S. I. N.	Date of Birth (*mmm/dd/yyyy*)	Province of Employment

SPOUSE (see reverse side for legislative definition of spouse)

Last Name	First Name	
S.I.N	Date of Birth (*mmm/dd/yyyy*)	Date of Marriage or Cohabitation (*mmm/dd/yyyy*)

BENEFICIARY (Applies only if you have no spouse or you have filed a spouse's waiver. If you name more than one beneficiary, death benefits will be divided in equal shares unless you indicate otherwise.)

Last Name	First Name	Relationship	Percentage
Last Name	First Name	Relationship	Percentage

CONTINGENT BENEFICIARY (Will apply only if no spouse and no beneficiary named is alive to receive your death benefits)

Last Name	First Name	Relationship	Percentage
Last Name	First Name	Relationship	Percentage

TRUSTEE FOR MINOR BENEFICIARY (Only if you are naming a beneficiary under age 18)

Last Name	First Name	Relationship

In accordance with the terms and conditions of IBEW Local Union 773 Pension Plan, I hereby revoke any previous designation of beneficiary made by me, and hereby appoint the above designated beneficiary to receive any payment in accordance with the Plan, that may fall due after my death. I reserve the right to change my beneficiary and/or contingent beneficiary from time to time, subject to government regulations on beneficiary designation which may apply, by filing a written notice thereof with the Plan Administrator.

SIGNATURE

Member	Date Signed (*mmm/dd/yyyy*)
Witness *(Other than your eligible spouse and designated beneficiary)*	Date Signed (*mmm/dd/yyyy*)

I.B.E.W. LOCAL 773 S.U.B. FUND - WINDSOR

APPOINTMENT OR CHANGE OF BENEFICIARY(IES)

INSTRUCTIONS:

You may name anyone you want as your beneficiary(ies). If you name more than one beneficiary, death benefits will be divided in equal shares among them unless you indicate otherwise. If you do not name a beneficiary(ies), SUB benefits will be paid to your estate unless otherwise indicated in your will.

Your contingent beneficiary will apply only if no beneficiary named is alive to receive your death benefits.

Be sure to complete this form in full and have someone other than your beneficiary(ies) witness it.

EMPLOYEE

Last Name	First Name
S.I.N.	

BENEFICIARY

Last Name	First Name	Relationship	Percentage
Last Name	First Name	Relationship	Percentage

CONTINGENT BENEFICIARY

Last Name	First Name	Relationship	Percentage
Last Name	First Name	Relationship	Percentage

TRUSTEE FOR MINOR BENEFICIARY (Only if you are naming a beneficiary under age 18)

Last Name	First Name	Relationship

I hereby revoke any previous designation of beneficiary(ies) made by me, and hereby appoint the above designated beneficiary(ies) to receive any payment in accordance with the Fund, that may fall due after my death.

SIGNATURE

Member	Date Signed (mm/dd/yyyy)
Witness (Other than your designated beneficiary)	Date Signed (mm/dd/yyyy)

I.B.E.W. LOCAL 773 VACATION PAY TRUST FUND

APPOINTMENT OR CHANGE OF BENEFICIARY(IES)

INSTRUCTIONS:

You may name anyone you want as your beneficiary(ies). If you name more than one beneficiary, death benefits will be divided in equal shares among them unless you indicate otherwise. If you do not name a beneficiary(ies), SUB benefits will be paid to your estate unless otherwise indicated in your will.

Your contingent beneficiary will apply only if no beneficiary named is alive to receive your death benefits.

Be sure to complete this form in full and have someone other than your beneficiary(ies) witness it.

EMPLOYEE

Last Name	First Name
S.I.N.	

BENEFICIARY

Last Name	First Name	Relationship	Percentage
Last Name	First Name	Relationship	Percentage

CONTINGENT BENEFICIARY

Last Name	First Name	Relationship	Percentage
Last Name	First Name	Relationship	Percentage

TRUSTEE FOR MINOR BENEFICIARY (Only if you are naming a beneficiary under age 18)

Last Name	First Name	Relationship

I hereby revoke any previous designation of beneficiary(ies) made by me, and hereby appoint the above designated beneficiary(ies) to receive any payment in accordance with the Fund, that may fall due after my death.

SIGNATURE

Member	Date Signed (mm/dd/yyyy)
Witness (Other than your designated beneficiary)	Date Signed (mm/dd/yyyy)